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ABSTRACT

Two booklets, "A Blueprint for Iowa's Young: Implementation Directions for the Framework Paper," and "Investing in Families, Prevention and School Readiness: Working Draft of a Framework Paper" present a framework for creation of a blueprint for implementation and management of community investment initiatives. The framework is based upon a careful analysis of current public spending and on effective prevention services. It focuses on families with very young children and provides a rational strategy for improving the school readiness (across health, development, safety, and social dimensions) of Iowa children who currently are not likely to start school ready to learn. The strategy of the initiative is to build upon existing effective and voluntary prevention and wellness programs that: (1) focus upon high-opportunity families with very young children; and (2) offer comprehensive guidance and support through home visits and other activities to stress and develop parental responsibility and work to improve family self-sufficiency and child development. The community strategy is to make most decisions regarding the design and implementation of the initiative at the neighborhood and community level. The first booklet outlines the principles that govern initiative design and offers initiative design guidance. Chapter 1 of the second booklet introduces the rationale behind early investment in children. Chapter 2 draws a connection between potentially preventable poor outcomes in the early years and subsequent public expenditures. Chapter 3 identifies problems and suggests solutions for improving the well-being of Iowa's youngest children. Chapter 4 examines the issues involved in developing a blueprint for initiatives. Appendix I presents estimates of current public spending on children and families and Appendix II presents current investments in prevention in the early years to High Opportunity Families. A brochure and 2 informational flyers present information relating to "A Blueprint for Iowa's Young Children." (AA)

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A Blueprint for Iowa's Young:

Implementation Directions for the Framework Paper

Investing in Families, Prevention, and School Readiness

Based Upon Work Group Meetings
of the Iowa Kids Count Initiative

June, 1994

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A Blueprint for Iowa's Young --

Investing in Families, Prevention, and School Readiness

Principles and Guidance for Implementing New State-Community Partnerships in Comprehensive, Community-Based Service Systems to Achieve School Readiness for Children in High Opportunity Families

June, 1994

[June Draft is based upon discussion and direction from five Kids Count Summit work groups meeting from February 16 through May 4, 1994.]

Introduction

The framework paper, *Investing in Families, Prevention, and School Readiness*, estimates that a comprehensive prevention agenda offering developmental supports to all "high opportunity" families in Iowa (families whose very young children are at risk of not receiving the health, nurturing, protective, and developmental supports to start school "ready to learn") would require an additional investment of $ 33.8 million annually. At the same time, developing effective services that are contoured to the needs of families and that draw upon community resources requires much more than state program funding. It requires the development of new service strategies, inclusive community planning and implementation approaches, new relationships between state governments

and communities, greater cross-system collaboration and integration of existing services and supports, and new methods for assuring that services produce improved outcomes and greater school readiness. In short, it requires a new way of doing business.

A successful, statewide prevention initiative requires more than development of written proposals and work plans at the community level. It requires inclusive planning that enlists participation from families who will be served, that builds community understanding of the need for action, that creates a high level of commitment within the community to making the strategy work, and that builds a capacity and an infrastructure at the state and the community level to implement new service approaches.

This new way of doing business must be reflected in the guidance, guidelines, and administrative structures that govern the expenditures of these funds. Through eight half-day meetings from February through May, 1994, nearly 100 Iowans guided the development of this draft blueprint. Five Iowa Kids Count work groups charged with developing this blueprint concentrated on the issues of: (1) community planning and capacity-building, (2) cross-system collaboration and service integration, (3) state-community partnerships in design and implementation, (4) outcomes and accountability, and (5) staff development, training, and technical assistance. They discussed both underlying principles that should be reflected in the guidance and guidelines established for these investments and the specific manner in which these principles could be incorporated into the actual design and implementation process.

The following provides both the principles that were emphasized in these discussions and a more specific design and implementation process that could govern these investments. They reflect a new way of doing business at the state, community, and neighborhood levels of service design and delivery.

Principles That Govern Initiative Design and Implementation

The following are the set of principles that work group members developed to undergird the initiative. They represent the foundation upon which the more detailed blueprint for implementation is based.

I. Overall Principles That Govern the Strategy for the Initiative

A. The goal of the initiative is to assure that all children start school "ready to learn," which requires that they be supported in the early years (prenatal to five) across health, safety, social, psychological, and developmental dimensions.

B. The focus must be on the family, and not the child alone, especially when dealing with very young children.

C. Parents have the primary responsibility for assuring that the needs of their children are met.

D. All parents want to love their children and therefore provide needed support for their development and school readiness; but some families (due to stress, absence of role models and support figures, lack of information, or economic and social deprivation) currently are not fulfilling that responsibility to a level that will ensure their children start school ready to learn.

E. Effective strategies exist to identify, engage, and support those families in fulfilling this responsibility, and the gains for doing so are substantial from both a social and economic perspective.

F. As such, these "socially vulnerable," "at risk," families constitute "high opportunity" families, because the potential gains from supporting them are profound.

G. These "high opportunity" families have different needs and require individualized supports, which requires a flexible approach that is capable

of assisting families and their children across a number of dimensions (health, nutrition, mental health, housing, substance abuse, adult literacy, family relations, parent-child interactions, child development, employment and economic security, housing, etc.).

H. Successful work with a family first is based on establishing a relationship, building trust, and then on working with parents to set and meet goals, which initially may involve basic needs and only at a later point involve child development goals.

I. Successful work requires that workers be able to access specialized services and supports for families when the families need them and therefore requires collaboration across systems serving children and families with young children.

J. Successful programs and services that support these workers must be contoured to the needs of the neighborhoods and communities they serve, and must become an integral part of those neighborhoods and communities.

K. This work is highly skilled and, on a family basis, highly individualized but must be accountable to having families make measurable progress on fulfilling their responsibilities to themselves and society.

II. Community Planning and Capacity-Building

A. The term "community" has several meanings: formal governing units that control public resources within an area (municipalities, county governments, school districts), neighborhood-based geographic areas (often around elementary schools) with which residents identify, and associational groups (churches, associations, colleagues, etc.) with which families identify. Each of these meanings is important to the initiative.

B. The process must meaningfully involve "consumers" of service, at all levels of service design, delivery, and implementation.

C. Where services are localized by neighborhood, as they will be in urban areas, neighborhood residents must be involved in the process, particularly around how services will be provided in their neighborhoods.

D. In order to construct a holistic approach, there should be a strategic plan and implementation strategy for the use of new funds that integrates these funds into existing services to families with young children.

E. The strategic plan and implementation strategy should tie its approach to achieving improved outcomes for the school readiness of children in high opportunity families.

F. The strategic plan and implementation strategy should describe how it will effectively reach and serve all high opportunity families throughout the community and respond to their needs.

G. The process for plan development and implementation should result in those with the authority to marshall resources (e.g. local governing and administering entities) placing those resources on the table for discussion and incorporation into planning and implementation.

H. There must be a sufficient commitment of time and effort to reach broad consensus and understanding of the vision and goals for service and of the challenges to achieving that vision and goals.

I. There must be accurate mapping and tracking of current resources that are being used to support high opportunity families and good information on the number of such families and their specific needs within a community.

J. The task of information collection and community assessment should be made as simple as possible for communities; and state level assistance should be provided to communities in this collection and interpretation.

K. The planning process should encourage innovation and individual adaptation, recognizing that not all innovations will show immediate gains or will succeed in their goals.

III. Collaboration and Cross-System Work

A. The emphasis in plan development should be to build upon existing service strengths and resources within communities, rather than designing entirely new service systems.

B. To be a part of the initiative, existing services and resources must demonstrate a commitment to become more comprehensive and more collaborative.

C. The goal is not simply to expand existing services as they currently are designed; it is to construct a system that is more family-focused, holistic, flexible, consumer responsive, and comprehensive. This will require many existing services to re-orient and restructure their approaches.

D. Participants/consumers should have a voice and ownership in the development and adaptation of service systems.

E. There should be an emphasis upon bridging between the professional and the voluntary, and the public and private; emphasis should be directed to linking service strategies to natural networks of support and development within communities.

IV. State and Community Partnerships

A. The state has a significant responsibility for setting the tone of the initiative as a community-based and directed one, using leadership rather than regulation to assist communities in their planning and implementation efforts.

B. The primary "regulatory" role the state should assume is in setting parameters around which the community planning process is constructed.

C. There should be expectations for a maintenance of effort of community resources directed to high opportunity families in exchange for participation in the initiative.

D. At the early stages, the state should assist in data collection activities that can help communities identify the numbers and locations of high opportunity families, and construct baseline outcome indicators that can be tracked through state data systems.

E. The state can play a leadership role in developing a network for providing technical assistance and peer-to-peer networking and support.

F. Such a network, which draws upon the expertise of successful innovations in helping other communities, also can provide recognition and reward for achievement.

G. Communities are in the best position to identify their technical assistance and support needs; they should have control over the selection of the technical assistance they want (and the providers who will give it).

H. Communities should participate in, and potentially direct, any mechanisms by which communities are held accountable for their use of initiative funds.

I. Most challenges to achieving success must be met at the community level, as success is contingent upon ownership and empowerment at the neighborhood and community level.

V. Initiative Accountability and Impact Upon School Readiness

A. An outcome orientation is needed for a variety of important reasons, to:
   1. inform resource allocation,
   2. justify program investments,
   3. allow the greater program flexibility accorded to communities,
   4. guide program directions, and
   5. hold services and workers on task to improving services.

B. The overall system for establishing benchmarks and outcome-based accountability must be constructed in the same manner that the initiative is developed, with shared ownership across state and community levels, and with strong involvement of grassroots, frontline workers and families served.

C. Efforts should be to measure "progress," not "final outcomes," recognizing that families have different needs and have different starting points around those needs.

D. An accountability system needs to be able to determine when workers are succeeding with families, and therefore should establish a system to measure whether workers are making progress with families.

E. Workers from current effective services need to be key participants in developing such an accountability system, based upon expectations for different measures for making progress with families over different periods of time (e.g. six months, one year, two years, five years, fifteen years).

F. The accountability system for determining when workers are succeeding with families should be used to guide program design, adaptation, and development and should be part of a quality improvement strategy.

G. The accountability system to assess worker effectiveness needs to be linked with society's expectations for children and families (e.g. healthy births, child protection/absence of child abuse or neglect, provision of primary and preventive health services, school readiness, school success/absence of school dropout or expulsion or below grade performance, social responsibility/absence of juvenile delinquency or adolescent pregnancy).

H. This accountability system needs to hold decision-makers responsible for resource allocations for other services needed to assure school readiness, in order to assure that there is a realistic match between needs of children and families and the configuration of services available to them.

VI. Staff Development and Support

A. Critical to the success of the initiative is a skilled workforce that can help families succeed in assuring their children start school ready to learn.

B. While effective workers can be credentialed in a variety of professional backgrounds or can be trained as para-professionals to do this work, the work is highly skilled and requires both pre-service and in-service training and support.

C. Systems for recruiting and selecting workers need to be developed to assure that candidates exhibit certain characteristics needed for effective work (empathy, tolerance of ambiguity, orientation to continuous problem-solving, positive life outlook).

D. Training strategies should include a variety of opportunities for learning, including shadowing other workers as well as interactive training sessions.

E. Programs that support workers should be structured as continuous learning centers and provide frequent staffings and systems of support for workers, so lessons learned can be transmitted across the program's workers.

F. An infrastructure needs to exist that can link programs and experiences, and provide assistance, though not dictate the form, of staff development practices.

G. Families served by the initiative should be an integral part of the training and staff development work, and evaluation systems should be designed to ensure that results are meaningful and helpful to workers.

H. The initiative must allow for sufficient time for communities, and programs, to create an organizational capacity to ensure that workers have the competencies they need.

Initiative Design Guidance -- A Blueprint for Establishing Community Investment Initiatives

The following is the embodiment of the underlying principles into a blueprint for initiative implementation and management, similar in many respects to a request for proposal (RFP) or set of administrative rules to govern an initiative. This Initiative Design Guidance spells out the responsibilities of the community and the state.

I. Core Structure of Initiative

A. Goal. The goal of the initiative is to improve the school readiness (across health, developmental, safety, and social dimensions) of Iowa children who currently are not likely to start school ready to learn. This goal is to be achieved through a service strategy of working with high opportunity families with very young children (prenatal to five) and a community strategy in planning, managing, and integrating this service into the community.

B. Service Strategy. The strategy of the initiative is to build upon existing effective and voluntary prevention and wellness programs focussing upon high opportunity families with very young children that offer comprehensive guidance and support through home visiting and other activities to stress and develop parental responsibility and work to improve family self-sufficiency and child development. The strategy requires coordination and collaboration across systems that serve those families and their children and outreach to ensure that all high opportunity families are encouraged to participate.

C. Community Strategy. The community strategy is to make most decisions regarding the design and implementation of the initiative at the neighborhood and community level. The initiative will operate throughout the state and be administered through community plans and management structures at the community level that are broadly reflective of the

communities and neighborhoods they serve. It is the expectation that most community plans and authorities will be developed on a county or multi-county basis, although sub-county geographic divisions may be established provided all parts of the county are included in a community plan. Communities do not need to construct new authorities to manage the initiative, but must be governed, at both the community and the neighborhood service level, by a broadly representative group that involves parents and participants.

D. Funding level. Funding available through the initiative will be provided based upon the number of high opportunity families that reside in the community, with the state-level oversight authority making the determination of the number of such families.

E. Phase-in. Initially, communities may use a portion of their allotment of funds for planning and capacity development purposes. There is no fixed timetable for completion of a plan or for subsequent full implementation of the plan, but the goal is to be fully using the funding available for serving families within three years of the establishment of the local governing body. It is acceptable for communities initially to choose to establish pilot or prototype service sites in order to learn as they move toward full implementation. While unused funding will not be carried forward for subsequent use, future funding will not be reduced because prior funding was not fully expended.

II. Community Responsibilities

A. General. This initiative represents a philosophy, a process, and a service strategy. Designing, planning for, and providing services and supports to these families is based upon innovation, collaboration, consumer participation, and broad-based decision-making. All of these concepts must be incorporated into the work in developing the strategic plan and implementation strategy needed to secure the service funds.

B. Applicants. Application for funding must be through a public institution, body, or consortium with the ability to receive and dispense funds, although that institution or consortium may contract with nonpublic entities for any aspects of the initiative. The governing body for the initiative must include representation from local governmental units that provide funding for services and supports to children and families, including, but not limited to, county boards of supervisors, school districts, and municipal government representation. Applicants may choose to include other representatives on the governing body or to use an existing unit that includes this representation.

The reason for the inclusion of local governing entities is that this initiative must be community-driven and should complement, integrate with, and influence other publicly-funded programs in the community that serve and support families with very young children. For the latter reason, representation from county departments of human services and public health, area education agencies, court services, and such other funders of service as United Way may also be selected to serve as members of the governing body.

C. Community Involvement. While the governing body provides the most direct contact with the state and has fiscal responsibility for the initiative, the management and direction of the initiative must occur through local collaboratives that involve all key stakeholders within the community and the neighborhoods that comprise the community These collaboratives must have the participation of individuals who have genuine authority to make decisions and commit resources.

It is expected that, in addition to the governing itself, other planning and management groups will be established to develop the strategic plan and implementation strategy. For this reason, the planning and design process must be a broadly inclusive one if it is to be successful. This involves much more than attaching twenty-five letters of support to the application. It means that current funders and service providers are willing to lay their resources on the table to discuss how they might be more effectively deployed. It means that consumers and the frontline staff who will be partnering with them participate at all levels of the planning and implementation process. It requires that planning and design occur at the neighborhood level as well as the community level, to involve neighborhood residents and assure that strategies are culturally and ethnically appropriate. It means that communities must create new linkages between a wide range of public, private sector, and voluntary groups and organizations.

The application process must describe how all stakeholders will be involved and must assure *effective participation* from consumers of service. Initially, the application may draw upon consumers from Head Start boards, community action agency boards, or other established boards that have involved service consumers and devised means for supporting these consumers in these roles. In the longer term, the goal should be to foster representation through a process where consumers select their own members. Unless the community can make compelling arguments to the contrary, the expectation should be that consumers shall constitute at least one-fifth of participants on all boards and committees of the initiative, and that frontline staff also are represented. The overall management structure

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for the initiative, and the levels of authority and responsibility that will be provided within this structure, should be specified.

Since it is envisioned that many of the services will be provided at the neighborhood level, it is important that neighborhood-based consumer involvement be incorporated within neighborhood-based sites and that specific service approaches be tailored to neighborhood cultural, linguistic, and ethnic strengths.

In addition, the planning process should involve meaningful interaction between administrative and policy setting stakeholders and frontline practitioners and consumers. This can be in the form of focus groups, site visits and extended discussions at exemplary local programs, neighborhood meetings in areas with high proportions of high opportunity families, or other means. The focus, however, should be on community dialogue and community interaction. An expectation of the application process is that members of the governing board themselves engage in these dialogues.

D. Core Elements of Strategic Plan and Implementation Strategy. Core elements of the strategic plan and implementation strategy that are developed by communities must include the following:

1. An articulation of the goals and philosophy that guide the initiative, how these were developed, and how they are consistent with community and neighborhood goals and values.

2. A description of the management structure and how that structure includes the inclusiveness of community involvement described in paragraph 2.

3. An assessment which identifies current service providers who are already working with high opportunity families and how their work will be incorporated into the initiative and connect with the initiative without duplication of service and support. Among the providers that should be engaged in this process are Head Start programs, WIC services, community action agency programs, child abuse prevention programs, early childhood education programs, family support programs, FaDSS programs, and adolescent pregnancy programs.

4. A list of the factors that will be used to define who represents a high opportunity family.

5. A description of how high opportunity families will be identified and

how outreach will maximize their participation and involvement.

6. A description of the core elements of the service approach that will be available to high opportunity families and how this will be secured across the providers and neighborhoods where services will be offered.

7. A description of how services will be located to be geographically accessible to families and correspond to natural neighborhood networks and associations.

8. A description of how the management of the initiative will ensure that lessons and experiences from the field (from frontline workers and from service consumers) will be incorporated into implementation and adaptation.

9. A description of how tracking of family and child progress will be used to foster family responsibility in meeting goals, to ensure continuous quality improvement, and to achieve gains in school readiness on a community-wide level.

10. A description of how the funds initially will be used and how they will be managed as the initiative grows and learns. The expectation is that the use of the funds will be to limited to providing home visiting and center-based services for high opportunity families that support greater self-sufficiency and school readiness, subject to the following:

    a. the community may expend up to 15 % of the service funds to support other innovative efforts to improve school readiness or other goals of the initiative, in recognition that communities have unique needs and resources and that there is a resultant need for opportunities to experiment with new approaches. In these instances, communities should seek to collect sufficient information, both process and outcome, to share the results of their efforts with other sites.

    b. the community may expend service funds to meet other needs of high opportunity families or other families if it can demonstrate that it is fully reaching its high opportunity families with comprehensive, developmental supports or that it has identified within the families it serves unmet needs that must be addressed for the comprehensive developmental supports to be effective.

III. State-Level Responsibilities in Assisting Community Plan Development and Assuring Initiative Goals are Obtained

A. Role. The role of the state is to provide leadership for the initiative, which includes facilitating the delivery of technical assistance, guidance in the development of initiatives at the community level, and arbitration of disputes. Since this constitutes a new way of doing business, the corresponding state-level management for the initiative itself is structured differently and its responsibilities are different.

B. Structure of State-Level Management Oversight. The initial oversight of the initiative shall involve a state-level management board that includes representatives from key state agencies (department of human services, department of public health, department of education, department of management), representatives from the governing bodies established at the community level (initially, individuals representing county boards of supervisors, local school boards, and municipal government and, over time, representatives selected by the authorities themselves) and representatives from those providing services at the neighborhood and community level. This management board shall have the rule-making authority for guiding the initiative and be responsible for arbitrating any disputes between local authorities and the state.

C. Initial Responsibilities of State-Level Authority.

Initially, the responsibility of the state management board is the following:

1. Disseminate information about the initiative to local governmental agencies and community groups. This shall include making follow-up contacts in communities that have not responded in a timely manner to the initiative.

2. Provide guidance and give interpretations of any core requirements for strategic plan and implementation strategy development as questions, concerns, or requests for clarification are raised by local authorities.

3. Provide demographic information and other available state-collected data that is needed to establish the number and location of high opportunity families, with data provided for urban areas on a neighborhood basis where data can be so disaggregated. This shall include census tract information and shall be provided in conjunction with the requests of the community for specific sub-community geographic breakdowns.

4. Offer technical assistance support in the planning stages of the initiative, including the development of a network of Iowa-based programs and services that can offer guidance to the design and development of initiatives.

5. Establish procedures for assuring a maintenance of effort within local communities.

6. Arrange for ongoing assistance, where requested, for drafting the elements of the strategic plan and implementation strategy.

7. Grant approval to plans as complete and ready for implementation funding or provide recommendations on the steps to be taken to make them complete and ready for approval.

8. Assure that all parts of the state are incorporated into a community plan. If there are any communities that do not constitute themselves to develop an initiative, the state management board shall assure that the families will be served either by incorporating them within the service area of a community which has formed or in identifying service providers who will provide services to high opportunity families until a community develops its own plan.

D. Ongoing Responsibilities of State-Level Management Board

The state management board has the ability to revise and restructure its responsibilities to meet the needs for the initiative's development. Initially included in the ongoing responsibilities for the board are the following:

1. Review other state and federal funds that serve high opportunity families and seek to remove state regulatory barriers to their flexible use to complement and integrate with the community initiatives,

2. Act in support of community requests for greater flexibility in the use of such funds and, where appropriate, decategorization of such funds,

3. Develop an "Iowa Diffusion Network" that offers local initiatives the opportunity to network among each other and build upon successful efforts, to offer peer-to-peer technical assistance, and to provide opportunities for recognition for exemplary initiative efforts.

4. Establish a framework for collecting and using information regarding initiative progress and family development at both the local and the

state level, and, at the state level, build a management information system that is not intrusive and does not collect unnecessary information but that helps guide investment strategies for families.

5. Establish an ongoing fiscal accountability structure that assures that funds are deployed for the purposes for which they are attended.

6. Mediate and resolve any disputes that may arise within communities which cannot be resolved at the local level. The state-level management board shall establish criteria regarding who may seek such mediation, assuring that this is designed to assure that inclusive participation in initiative design and implementation occurs at the local level.

7. Oversee the development of worker training and development capacities to meet the need for such training support throughout the state.

8. Oversee the development of mechanisms to resolve issues about the ongoing capabilities of local initiatives to meet the objectives outlined in Section IV.

IV. Developing an Outcome-Based Accountability and Quality Improvement Structure for the Initiative

A. The state management board shall work with the Council on Human Investment to clarify how the initiative will coordinate efforts and exchange information to assure that initiative activities remain consistent with the Council's goals and benchmarks.

B. The state management board shall construct a working group that includes workers and supervisors from exemplary programs in the state that provide developmental and comprehensive support to families with young children. The working group will develop realistic means for measuring family progress as a result of the initiative effort on a family basis, across a variety of dimensions of well-being.

1. The working group shall construct measures of progress across dimensions of family well-being, including housing, health, mental health, substance use, employment and income security, adult education, parent-child relationships, child development, family functioning, and social involvement.

2. The working group shall construct realistic expectations for showing

progress across these dimensions over different time periods of a working relationship with families -- during the initial outreach and trust-building period, over the course of the first year of involvement, by the end of two years' involvement, and over the long-term.

3. The working group shall work to continually refine these measures, based upon initiative experience, with particular attention given to establishing an overall baseline of family starting points and needs across the population of families to be served.

4. The working group shall establish connections between these measures of progress with the benchmarks for child and family well-being that have been identified by the Council on Human Investment and that correspond to society's expectations for children and families..

C. This method for measuring family progress shall be incorporated into a management information and tracking system that may be used by local sites to: guide worker efforts, provide a mechanism for assessment of initiative effectiveness, determine gaps in services, measure the demand for services, and provide for continuous quality improvement in working with families.

D. The tracking system shall include information on other specialized and professional services and supports that are identified to be necessary for the family to make progress and the extent to which these can or cannot be secured. If they cannot be secured, the system should identify the reasons they cannot be secured (lack of geographic accessibility, insufficient resources to provide service, provider resistance, etc.) and recommend ways to address these concerns, including modifying the initiative to redirect funding to these ends.

E. The management board shall draw upon resources both within the state and nationally in order to develop the means to assess worker success in achieving family progress and commit the resources needed to achieve these ends. The first iteration of this assessment will occur within eighteen months of the creation of the initiative.

V. Meeting the Training, Staff Development, and Technical Assistance Needs of Local Initiatives

A. The management board shall develop a consensus job description for workers involved in providing developmental support to families with young

children, drawing upon the experiences of existing exemplary programs in the state, the organizational culture and climate needed to support those workers, and the pre-service and in-service staff training and staff development systems needed to develop needed worker skills.

B. The management board shall develop a consensus job description for those who would be charged with supervising and directing these workers and collaborating with other neighborhood and community organizations and institutions, and the pre-service and in-service training and staff development and networking support needed by these directors.

C. The management board shall construct a working group that includes consumers, workers, supervisors, and those experienced in training that will determine the core skills in which workers and directors must receive training. The working group shall provide assistance to communities in developing training and staff development strategies to support these workers and directors and require that each community incorporate into its initiative budget necessary funding support for training and staff development.

1. Communities should be provided the opportunity of developing their own training and staff development programs or purchasing these elsewhere, but the management board shall establish criteria to assure that training and staff development efforts assure the development of certain minimum skills.

2. Training may take a number of different forms, including shadowing other workers as well as classroom training programs on general process issues of working with families and seminars on dealing with specific family needs, but the emphasis should be upon interactive instructions.

3. Training and staff development efforts should be closely connected to the evaluation and assessment and quality improvement tracking and information systems established for the initiative.

D. The working group shall review all local training programs to ensure they will provide training that will ensure that workers and directors acquire the core skills enumerated by the working group.

E. Communities must demonstrate that workers receive training and support that will ensure mastery of the core skills enumerated by the working group, as a condition for receiving funding under the initiative.

F. The management board shall survey communities to assess the need for the development of a core training curriculum that can be offered on a regular, regional basis throughout the state. If there is sufficient belief in the need for a core training curriculum or interest in developing one, the management board shall work with interested communities to construct the structure needed to provide that core training curriculum.

For Additional Information

The Child and Family Policy Center administers the Iowa Kids Count grant, part of the national Kids Count Initiative funded by the Annie E. Casey Foundation. The Child and Family Center was founded in 1989 by Tanager Place to "better link research and policy on issues vital to children and families."

In addition to the blueprint, Iowa Kids Count has produced a framework paper, *Investing in Families, Prevention, and School Readiness*, which establishes the potential gains from a prevention agenda. Iowa Kids Count also has produced its annual report, *Reinventing Common Sense*, which summarizes the framework paper and provides program descriptions of six effective demonstration programs serving families with young children. Copies of these reports are available by contacting the Center.

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Investing in Families, Prevention and School Readiness

Working Draft of a Framework Paper

Iowa Kids Count Summit

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INVESTING IN FAMILIES,
PREVENTION AND SCHOOL READINESS

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CHAPTER ONE:

THE CASE FOR EARLY INVESTMENTS IN CHILD WELL-BEING

*At age forty eight, John Smith has become a million-dollar Iowan. He did not win the Iowa lottery or become a millionaire. Rather, he has now cost Iowa taxpayers over $ 1 million for his care and for society's protection. John Smith has spent twenty years of his adult life in correctional institutions (most for reasons of burglary and robbery but also for violent actions) and over three years of his adolescent life in training schools and residential treatment programs. His prison time (25 years * $ 18,000) has cost the state $ 450,000, his juvenile treatment an additional $ 175,000. Probation services during the times John was not locked up have amounted to $ 40,000. Court expenses for his prosecution and his appeals have cost over $ 150,000. Special medical bills for preventable neurological disorders have cost another $ 175,000.*

John Smith's mother did not have a high school diploma, and lived most of her life in poverty, sometimes on public assistance. When she gave birth, she had had no prenatal care and her son was born prematurely and at low birthweight. John suffered from hyperactivity and a chaotic home environment. His mother was unable to control him by the time he was seven, and John was abused by his stepfather. John was a disciplinary problem in school, and never completed tenth grade, although he finally got a GED in prison, aided by the completion of some training programs in the training school.

John estimates that, in addition to the costs to taxpayers, he has robbed Midwestern residents in the vicinity of $ 300,000 in goods. During the times when John has lived in society as an adult, he has fathered two children, one of whom has been in five foster homes and now is a candidate for the state training school. John may well have helped insure that Iowa has a new generation of million-dollar Iowans.

This story of John Smith is a fictionalized one, but one representative of too many Iowans today. Few will argue that expenditures on remediation services and public protection for people like John are ones Iowans do not want to have to make.

This framework paper is entitled, "Investing in Families, Prevention, and School Readiness" because it discusses the "costs of failure" that society bears and that are typified by the case of John Smith. It also draws from the research literature information regarding prevention strategies that have shown promise of averting these poor outcomes and attendant social costs. As will be discussed later, it focusses upon the early years of a child's life (prenatal to school-age) and thus with state and national health and educational goals for young children, best typified in the First National Educational Goal on school readiness.

The extent of the "costs of failure" to Iowa society is the subject of the second chapter of this paper. Even though it is difficult to precisely measure the magnitude of these costs, it is necessary to determine current costs associated with preventable poor outcomes in the early years to show the extent of the problem. Determining these overall costs puts into context the cost of current and potential prevention and school readiness programs.

In John Smith's case, one can find points at which actions could have been taken which could have resulted in a better outcome for both John and for Iowa. Since this is a fictionalized case, the scenario could have been different:

> *<u>If</u> John's mother had received support and counselling and prenatal care during pregnancy, she might have given birth to a normal birthweight baby, without any neurological disorders. <u>If</u> she had received enhanced training and family development opportunities, she might have provided a more economically-secure home. <u>If</u> a Head Start or other quality preschool program had been available, John might have started school on a par with his class, more ready to succeed. <u>If</u> health care were provided on a primary and preventive basis as an infant and toddler, John may not have needed so much medical attention as an adult. <u>If</u> John's family had been involved in parenting programs and home visiting, he might not have been abused as an infant and angry as a teenager. Finally, <u>if</u> John had been encouraged, he might have completed high school and developed his own career.*
>
> *In short, preventive investments (in the thousands, rather than the hundreds of thousands of dollars) in the early years of John's life might have helped him to become a contributing member, rather than a threat, to society. <u>If</u> he had earned at even three-quarters of the median income level for his age group during this period, he would have <u>paid in Iowa taxes,</u>*

over a thirty-year period, more than $ 50,000. Most importantly, his children would be on paths to success and not to dependency. Overall, John would have contributed hundreds of thousands of dollars to society, rather than draining society of those amounts.

Again, everyone will agree that this second scenario is highly preferable, from both society's and from John's perspective. The challenge in constructing a prevention agenda is to identify ways that society, including government, can put into place supports and services that can turn around lives like John's.

Similar to the task of identifying the "cost of failure" for people like John, identifying successful prevention initiatives that can turn those into successes is a complex one. Estimating the costs of such investments and their impact upon society's expenditures on maintenance and remediation services and on public safety also cannot be done with precision. The best available research provides only partial answers to questions, and many assumptions have to be built into this work.

Chapter Three provides a first effort to define an investment strategy for prevention and school readiness that is built upon existing efforts and upon knowledge of what is needed to produce changes in the lives of people like John. In addition to defining an investment strategy, it also seeks to identify the resources currently being expended on those at-risk, "high opportunity families" that would be the targets of such services.

The framework paper attempts to address the three critical questions raised by policy makers and the public in seeking to develop a result-oriented and outcome-driven public policy to meet health and education goals already established for children at both the state and the national level:

- What works?
- How much will it cost?
- What will we stand to gain by doing it?

The focus in this framework paper is on investments made in prevention in the early years of life -- prenatally to school age -- that can reduce later problems and social costs. Similar work could and should be done on other developmental stages, and the Iowa Kids Count Initiative may extend its work to those stages at another time. The focus upon Iowa's young and their families was selected for three very important reasons:

- the early years in a child's life are particularly

crucial to a child's development and growth, with life-long impacts and therefore profound potential impacts upon society well-being,

- a good deal is known about how the lack of support to young children affects them later in life (especially as reflected in the relationship of poor birth outcomes, poor early nurturing and support, and lack of developmental readiness for school to future problems experienced as children and as adults), and

- there is significant interest among Iowans in developing strategies to address child needs during these early years, although this remains an area of limited public commitment of resources.

In developing this framework paper on "Investing in Families, Prevention, and School Readiness," a concerted effort has been made to use the best available research and information to determine the current costs to Iowa of preventable problems and remediation services and to suggest the types of investments that could help reduce these costs in the long-term. This includes information from many Iowa programs and initiatives, as well as from national models and research conducted throughout the country. In the end, however, there are many gaps in research and information that required that assumptions be made in order to estimate potential impact and cost. The framework paper seeks to be conservative in drawing conclusions from research, and to make clear what assumptions are made in developing estimates.

The resulting framework paper is not a definitive statement on the subject of prevention, but rather a document designed to produce public dialogue and debate. Not all may agree with its conclusions, but all should agree that it places forward a powerful challenge that Iowa policy makers and the public should not ignore.

The final chapter discusses the implications both for financing and implementing such a prevention and school readiness agenda. Turning the framework paper into a blueprint will only occur through public dialogue and debate and the development of a deep commitment to investing in Iowa's young so that all society may benefit.

CHAPTER TWO:

THE HIGH COST OF FAILURE IN IOWA TODAY

Business people know that it is less expensive to prevent failure than to try to correct it later. Early intervention for poor children from conception to age five has been shown to be a highly cost-effective strategy for reducing later expenditures on a wide variety of health, developmental, and educational problems that often interfere with learning. Long-term studies of the benefits of pre-school education have demonstrated returns on investment ranging from $ 3 to $ 6 for every $ 1 spent. Prenatal care has been shown to yield over $3.38 in savings on the costs of care for low-birthweight babies. Early immunization for a variety of childhood diseases saves $ 10 in later medical costs. Supplementing nutrition for poor women, infants, and children yields a $ 3 payback in savings on later health care costs.

At the same time, the costs of not intervening early can be astronomical. Every "class" of dropouts earns about $ 237 billion less than an equivalent class of high school graduates during their lifetimes [and] government receives about $ 70 billion less in tax revenues. Each year, taxpayers spend $ 16.6 billion to support the children of teenage parents. About 82 percent of all Americans in prison are high school dropouts, and it costs an average of $ 20,000 to maintain each prisoner annually.

-- Committee for Economic Development, The Unfinished Agenda: A New Vision for Child Development and Education, p.11.

I. Introduction

The statistics presented in this simple statement from the Committee for Economic Development are powerful because they are presented by a tough-minded group of the country's top corporate and education leaders. They are also powerful because they are supported both through research studies and through common experience.

While Iowa is fortunate among states to have one of the highest rates of high school completion in the country and one of the lowest proportions of low birthweight infants, Iowa still has too many very young children who experience preventable poor outcomes at birth, who do not thrive in a nurturing environment as infants, and who do not start school ready to learn.

As a result, Iowans bear the resulting social costs associated with delinquent and criminal behavior; school drop-out, unemployment, and dependency; and health care obligations to treating preventable health conditions. State and local budgets today include expenditures for compensatory and remediation services, for maintenance programs providing a safety net for families who are not economically self-sufficient, and for public protection that would not be needed if effective prevention programs existed for very young children and their families.

Not all social expenditures on remediation, maintenance, or public protection are preventable, of course. Society's best efforts and the medical community's greatest skill, cannot eliminate all premature births or all congenital defects. Despite strong nurturing and family support, some children will not adjust socially and will commit delinquent acts. As adults, some will commit crimes and require incarceration. Some will not succeed in school. Others, because of the circumstances of their parents and economic changes due to unemployment, divorce, separation or unplanned parenthood, will require at least temporary economic support.

At the same time that it is recognized that not all such social expenditures are preventable, it also must be recognized that public programs cannot be designed to successfully address all preventable outcomes giving rise to these expenditures. While public programs can play a role in preventing poor outcomes, informal, community networks of support also are needed. Even then, some families may not take advantage of these prevention opportunities or society may not identify their needs until a point of crisis is reached and remediation services, rather than prevention services, are required.

Developing a "Blueprint for Iowa's Young" based upon the power of prevention in the early years requires that both these limitations on the potential for public prevention efforts are clearly recognized. At the same time, however, it is essential that investments in prevention be placed in their proper context. Programs are designed to prevent future social problems and their costs. They represent a potential alternative to the manner in which scarce public resources currently are being expended.

To set any "Blueprint for Iowa's Young" in its proper context, it is necessary to identify what current Iowa social

expenditures (on remediation, maintenance, and public protection) are preventable and what increased economic activity is possible if very young children start their lives more likely to achieve their full potential. That is the subject of this chapter of the framework paper. After this context has been established, the third chapter will suggest what types of public investments in services show the most promise for prevention and for full development of Iowa's young.

The next section of this chapter reviews the current knowledge on the connection between preventable poor outcomes in the early years and future social problems and costs. It describes the associations that have been found between preventable poor birth outcomes, failures to provide early nurturing support, and failures to provide developmental support all translate into future social costs.

Based upon that section, the third section examines 1992 public expenditures (state, federal, county, and school) on children and families evaluated in the context of their emphasis upon prevention, remediation, maintenance, and public protection. This new approach to examining public expenditures clearly demonstrates that investments in prevention play a relatively small role in overall financing of services for children and families.

The fourth section then examines the potential gains that Iowa might make in reducing poor outcomes in the early years. While not all poor outcomes are preventable, evidence clearly exists to show that substantial improvements can be made for Iowa children in the early years. The final section summarizes the chapter.

II. The Associations Among Poor Early Childhood Outcomes and Other Social Costs

Opportunities for prevention occur throughout the early years. While the development of children through the first years of life requires a variety and a continuum of supports, the existing research and prevention literature tends to examine separately three specific stages of support for very young children and their families:

- perinatal (prenatal through the first year of life) support in assuring a healthy start in life;
- family and parenting support in the infant and toddler period (from birth to age three or four) in assuring bonding, nurturing, protection, and exploration; and

- o developmental support in the pre-school period (three and four year-olds) in assuring school readiness.

Somewhat different associations between poor outcomes in each of these stages and later social costs have been demonstrated, although there are many common themes. While prevention efforts which provide a continuity of support through these periods are recognized as being most successful (a subject of the next chapter), for purposes of describing the links between poor outcomes in the early years and subsequent social costs, each is discussed separately below.

A. Poor Birth Outcomes and Subsequent Social Costs.

It is not possible to quantify the human costs of poor birth outcomes to the infants and to their parents, relatives, and friends. Poor birth outcomes include the tragedy of infant mortality, the short-term and long-term impacts of morbidity, and the effects of life-long disabling conditions. Poor birth outcomes are associated with social costs in increased medical costs during the neonatal period, in increased health costs resulting from treating mild and severe disabilities, and in increased costs and lost opportunities educationally and socially. Poor birth outcomes often are tied to family social and economic conditions, with both the medical and social conditions surrounding the infant contributing to subsequent problems and costs.

Research on poor birth outcomes that has sought to associate those outcomes with future social costs has focused either upon the relationship between low birthweight and future costs or the relationship between preventable disabilities and future costs. This research is discussed separately below, and the relationship between poor birth outcomes and later social costs is then summarized.

1. Low Birthweight. Much of the literature associating poor birth outcomes to later child outcomes does so by contrasting infants born at low birthweight (under 5.5 pounds) with those born at normal birthweight. In fact, low birthweight is strongly associated with prematurity, which is the stronger causal factor for poor outcomes than is low birthweight itself. Low birthweight has been used, however, because it is so closely connected with prematurity and because that information is easily available and does not require estimation.

The medical costs during the perinatal period for caring for low birthweight babies has been well-documented as significantly higher than that for babies born at normal weight. In 1990, more than $2 billion was spent for hospital-related costs for neonatal care (delivery and the first 30 days of an infant's life) of low

birthweight infants. The average costs for a low birthweight baby were $ 21,000, compared with an average cost for a normal delivery of $ 2,800. Although representing only 7 percent of all births, low birthweight newborns account for approximately 57 percent of all hospital costs for neonatal care.[1] Figures such as these have led the United States Congress' Office of Technology Assessment to conclude that:

> for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health system saves between $14,000 and $30,000 in newborn hospitalizations, rehospitalizations in the first year, and long-term health care costs associated with low birthweight.[2]

In addition to neonatal costs, low birthweight (and particularly very low birthweight) is associated with a variety of long-term disabilities and their attendant health care costs. Low birthweight infants are three times more likely than normal birthweight infants to experience neurological problems such as cerebral palsy and seizure disorders. Further, the risk increases as birthweight decreases, with up to 19 percent of very low birthweight babies so affected.[3] An estimated 11,000 low birthweight babies annually suffer from avoidable long-term disabilities, including mental retardation, cerebral palsy, blindness, seizure disorders, developmental delays, and learning disabilities. Very low birthweight children are much more likely to experience multiple problems and morbidity at school-age, regardless of the economic background of their families, although the risk is highest among low-income families.[4] The financial responsibility for providing long-term habilitation and rehabilitation services for children and adults with disabilities is immense.

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[1] Minor, A.F. The Cost of Maternity Care and Childbirth in the United States, 1989 (Research Bulletin: Health Insurance Association of America: December, 1989).

[2] Office of Technology Assessment. Healthy Children: Investing in the Future (U.S. Congress: Washington, D.C.: 1988).

[3] American College of Obstetricians and Gynecologists. Strategies and Options for Improving Access to Maternal Health Care: The Obstetrician-Gynecologist as Advocate (Washington, D.C.: September, 1988).

[4] McCormick, Marie, et.al., "The Health and Developmental Status of Very Low-Birth-Weight Children at School Age," Journal of the American Medical Association (April 22/29, 1992: Volume 267, Number 16). p. 2204-2208.

Further, the costs of low birthweight and attendant poor birth outcomes are not confined to health-related care and services. Children born at very low birthweight are approximately three times more likely than children born at normal birthweight to require special education services and to experience school failure (grade repetition and eventual school dropout). Children born at low birthweight are 50 percent more likely to require special education services or experience school failure.[5] One-half of children born at very low birthweight have IQs under 85, and those of low birthweight are twice as likely to be hyperactive.[6]

Finally, prenatal care and nutritional and social supports can reduce the incidence of prematurity and low birthweight and their resulting impacts.

2. Preventable Disabilities During Pregnancy. While low birthweight and prematurity are associated with a variety of disabilities, there is substantial research into the causes of disabilities themselves that traces a significant number of preventable disabilities back to the prenatal period. Studies estimate that anywhere from 10 to 50 % of all cases of mental retardation are preventable.[7] Many of these are preventable through early detention and treatment of medical conditions, which is the reason that entry into early prenatal care is so important.

Improved diagnosis and treatment of medical problems during pregnancy can improve birth outcomes. For instance, women with phenylketonuria (PKU) who have high levels of phenylalanine in their blood during pregnancy are at a very high risk of delivering children with severe mental retardation and other

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[5] Newman, L. and S. Buka. Preventing Risks of Learning Impairment, A Report for the Education Committee of the States (January, 1991).

[6] U.S. Department of Health and Human Services Office of Communications. Fact Sheet on Healthy Start (May 1992).

[7] See: The Iowa State Plan for the Prevention of Developmental Disabilities (January, 1989) for much of the literature cited in this section regarding the poor birth outcomes and disabilities. This document includes a very complete analysis of the research linking both medical and non-medical prenatal services and supports during pregnancy to reducing disabilities at birth and in later life. The 50 % figure is that presented by the President's Commission on Mental Retardation and has been widely referenced, although most researchers suggest that a lower figure is more realistic.

developmental disabilities. Women with epilepsy who take anticonvulsants during pregnancy have approximately twice the risk of delivering offspring with malformations as do those in the general population. Control of these and other medical problems during pregnancy has been shown to reduce the incidence of developmental defects at birth.

Changes in maternal behavior during the prenatal period also can improve birth outcomes significantly. For instance, smoking and drinking both contribute to poor birth outcomes, with smoking being one of the strongest predictors of low birthweight and also associated with respiratory problems and sudden infant death syndrome.[8] Fetal alcohol syndrome affects at least one in one thousand infants born, with many times that number of infants born with less severe fetal alcohol effects. Fetal alcohol syndrome produces lifelong costs to society in the hundreds of thousands, if not millions, of dollars, per affected infant, yet is entirely the result of behavior that is preventable.[9]

The costs of preventable disabling conditions are reflected in medical care expenditures, special education costs, and the costs for habilitation and rehabilitation services, and in maintenance services, in some cases involving lifelong institutional support.

On the medical side, children with severe chronic health impairments use a large proportion of all dollars spent on child health care. Butler et.al., using data from the early 1980s, estimated that about 4% of children with severe illnesses used at least 20-30% of the child health dollar.[10] More recently, Lewit and Monheit (1992) estimated that 1% of the childhood population accounts for 37% of personal health care expenditures on children (based on the 1987 National Medical Expenditure Survey).[11]

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[8] Kleinman, J., et.al., "The Effects of Maternal Smoking on Fetal and Infant Mortality," American Journal of Epidemiology, Vol. 27, 1988. Pp. 274-282

[9] ibid.

[10] Butler, JA, P Bedetti, MA McManus, S Stemark, and PW Newacheck, "Health Care Expenditures for Children with Chronic Illness, in Hobbs, N and JM Perrin (eds.) Issues in the Care of Children with Chronic Illness (San Francisco: Jossey-Bass: 1985). pp. 827-863.

[11] Lewit, EM, and AC Monheit, "Expenditures on Health Care for Children and Pregnant Women," The Future of Children (Volume 2, 1992) p. 95-114.

3. Summary. In summary, the link between poor birth outcomes, as reflected in low birthweight generally and in physical and mental disabilities specifically, is very strong. Studies have shown strong associations between poor birth outcomes and many subsequent social costs. Table One provides a listing of these associations:

TABLE ONE

PREVENTABLE POOR BIRTH OUTCOMES AND SUBSEQUENT SOCIAL COSTS

Low (and very low) birthweight, prematurity, untreated medical conditions, and high risk personal behaviors have been determined to increase:

- *neonatal hospital and medical costs,*
- *medical costs for caring for chronic and severe health conditions,*
- *special education expenditures,*
- *school dropout costs,*
- *mental retardation and its attendant costs,*
- *developmental disabilities and their attendant costs, and*
- *neurological disorders (including fetal alcohol syndrome) and their attendant costs.*

As will be discussed more thoroughly in Chapter Three, providing comprehensive services (including persistent outreach) to pregnant women can reduce low birthweight and increase the proportion of healthy births. Moreover, the potential gains from such services, even in the short term, have prompted organizations like the Committee for Economic Development to quote savings of $ 3 for every $ 1 invested in prenatal care.[12]

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[12] The figure is drawn from a sophisticated simulation constructed by the Institute of Medicine that concluded that prenatal care is cost-effective, saving $ 3.38 in medical costs

B. Insufficient Nurturing in the Early Years and Subsequent Social Costs.

The human growth and development literature has amply documented the critical role that a child's first years play in long-term growth and development. During these years, the child develops his or her ability to trust and form relationships with others and explore the world and develop. A consistent source of support, affection, and protection is critical to social development into adulthood. The first few years of life are considered the most critical to an individual's lifelong ability to function.

Since there has been no universal public contact with all children during these years (as there is on a nearly universal basis at birth with the delivery of the child in a health care setting), and because nurturing is more difficult to describe and measure than is low birthweight, there have been fewer precise relationships established between essential nurturing in the early years and subsequent child outcomes.

At the same time, however, there are several different areas of research that provide substantial evidence of the extreme importance of nurturing in the early years to subsequent development. This includes the literature on the effects of abuse and neglect during the early years and subsequent development; the experiences programs offering developmental supports to families with young children have had on subsequent child development; the relationship between providing basic health supports such as immunizations during the early developmental years and subsequent health costs; and the relationship between early identification and treatment of disabilities and future child growth and development. Each is discussed below.

1. Abuse and Neglect. The first years of a child's life are critical to the child's development in both a physical and a social sense -- in bonding, establishing a personal identity and sense of well-being, in approaching life. At the same time, they are stressful times for families, where responsibilities increase dramatically. It is during the most important first years of

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during the neonatal period for every dollar expended on providing prenatal care. See: Institute of Medicine: Preventing Low Birthweight (Washington, D.C.: National Academy Press: 1985). For a more complete review of this literature, see: Bruner, Charles and James Perrin. Going to Scale: Comprehensive State Initiatives to Improve Infant and Child Health (Milbank Memorial Fund: Forthcoming).

life that family stress can result in abusive or neglectful actions. While the consequences of deprivation or abuse occurring in later years often can be remediated through counseling and social support, the psychological literature is clear that a child who has been denied the opportunity to bond or has been subjected to physical and emotional abuse during the early years faces serious obstacles to healthy development.

The experiences of children brought into the child welfare system for reasons of abuse and neglect and their subsequent experiences in life provide one indication of the social costs that insufficient nurturing in the early years brings. Experts in child psychology and child development are in general consensus that signs of abuse and neglect in the early years are strong forewarnings of later involvement in the foster care or juvenile justice systems. The majority of prisoners in the adult correctional system began their lives in families that were disorganized, chaotic, dysfunctional, abusive, or neglectful and where they did not receive consistent nurturing and support.

Two studies of the adult homeless population found that twenty-five and thirty-eight percent of homeless adults, respectively, had been in foster care for some period in the childhood, although fewer than 2 % of all adults have experienced such out-of-home care. A 1991 government study of young people who recently left foster care found that 25 % had been homeless for at least one night, 40 % were on welfare, 46 % had dropped out of high school, and 51 % were unemployed.[13] Different studies of youth institutionalized as juvenile offenders indicate that 26 % to 55 % had official histories of child abuse as well, often occurring very early in life.[14] Of a more clinical nature, placement of a child outside the home for reasons of abuse or neglect has shown to result in slower intellectual growth, lack of selectivity in friends, more anxious and aggressive behavior, and greater likelihood of mental illness.[15]

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[13] A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth (Phase 2 Final Report: Volume I: prepared for the U.S. Department of Health and Human Services by Westat, Inc.: 1993).

[14] U.S. Select Committee on Children, Youth, and Families, U.S. House of Representatives. No Place to Call Home: Discarded Children in America (Government Printing Office, Washington, D.C.: 1990), p. 34-5.

[15] Kinney, Jill, David Haapala, and Charlotte Booth. Keeping Families Together (Aldine de Gruyter: New York: 1991). Review of research findings from other sources. P. 18-9.

2. Providing Developmental Supports and Improvements in Child Well-Being. Over the past several decades, a number of research demonstration programs have attempted to intervene early with families to prevent abuse and neglect and to improve family functioning and child development. Most of these efforts have focussed upon families experiencing some level of stress or risk (or, as will be discussed in Chapter Three, "high opportunity families"). One of the most highly regarded and cited programs, the Prenatal/Early Infancy Project (PEIP), used professional staff to provide support to pregnant women who were poor, unmarried, or teenaged in the rural Appalachia area near Elmira, New York. Nurses conducted home visits to provide information about fetal and infant development, helped involve family members and friends in the pregnancy and early care of the child, and promoted linkages to formal health and human services. They also encouraged mothers to clarify plans for completing education, returning to work, and having additional children.

Compared with mothers who received a more limited set of services, mothers receiving nurse home visiting reported that their babies were happier. They punished their children less frequently, provided their children with more play materials, and took them to the emergency room less often. Most importantly, the rate of child abuse was lower among these families than those receiving fewer services, and the scores of the children on tests of intellectual functioning were higher.[16] Other studies of demonstration programs providing comprehensive supports to new families to support nurturing have shown improved outcomes in reduced levels of repeat pregnancies among adolescents, improved parental educational attainment, and reduced welfare dependency as well as improved child development.[17]

3. Health and Immunizations. In addition to the studies on the impact of providing social supports to new parents, there exists substantial evidence of the value of primary and preventive health services for infants and toddlers.

Nationally, it has been cited widely that one dollar spent on immunizations can save up to ten dollars on later treatments

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[16] Olds, D.L., C.R. Henderson, R. Chamberlin, and R. Tatelbaum, "Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation," Pediatrics 78 (July 1986). Pp. 65-78.

[17] For a review of a number of these programs, including the Elmira project conducted by Dr. Olds, see: Daro, Deborah. Intervening with New Parents: An Effective Way to Prevent Child Abuse (National Center on Child Abuse Prevention Research: February, 1988).

of the immunizable disease. Vaccines are relatively inexpensive, and costs of child hospitalizations for diseases such as measles, whooping cough, and polio are extremely high. Therefore, it requires few averted hospitalizations to cover the costs of many immunizations. Moreover, since low immunization rates increase the risk of epidemics and the spread of infection, making the spread of infections and epidemics possible, raising immunization rates reduces the outbreak of diseases even for those not immunized.

A graphic example of these cost can be found in the recent public health history in Milwaukee, which experienced a measles epidemic in 1989 and 1990 due to the low immunization rate of infants and toddlers. As a result, there were over 1000 cases of measles, with 233 requiring hospitalization, with a total cost of $ 2.3 million in hospitalizations alone, and many additional costs in other medical care and services. After the outbreak occurred, a broad-scale immunization effort was undertaken, with the Health Department immunizing over 20,000 patients free of charge, at a cost of approximately $ 500,000. The Health Department estimated that all two year-olds could have been immunized prior to the outbreak for $ 300,000 and Milwaukee's children could have completely avoided the epidemic and its $ 2.3 million cost.[18]

Immunizations represent only one aspect of a preventive health care agenda for infants and toddlers. Early detection and treatment of a variety of childhood conditions can improve child functioning and reduce later health and developmental problems. As one illustration, screening for lead poisoning and the subsequent removal of lead risk has been estimated to be highly cost effective in preventing subsequent health costs and developmental problems.[19] Simply identifying and treating

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[18] Presentation of Paul Nannis, Commissioner of Health of the City of Milwaukee, to the Robert Wood Johnson Foundation's Des Moines Hearing, "Conversations with Americans," chaired by First Lady Hillary Rodham Clinton, February, 1993.

[19] For an estimate of the potential savings in medical care and compensatory education for reducing the neurotoxic effects of lead in children of more than $ 500 million annually (in 1983 dollars), see: U.S. Office of Technology Assessment. Neurotoxicity: Identifying and Controlling Poisons in the Nervous System (U.S. Office of Technology Assessment: Washington, D.C.: 199)). The Environmental Protection Agency has made similar estimates, based upon reduction in the number of children at risk of requiring medical treatment, losing points of IQ, requiring compensatory education, having stunted growth, or having hematological effects requiring care. See: Miller, C.A. et.al.

hearing problems has been shown to improve early childhood development and increase the likelihood that children start school ready to learn.

Important in this discussion of the association between primary and preventive health care services for infants and toddlers and later health conditions and developmental problems is that this discussion also relates back to more general supports for family nurturing. Parents represent the first providers of health care to their children and are responsible for assuring they receive primary and preventive services. Families under stress and at risk of failing to provide sufficient nurturing and support to their children are those least likely to arrange for medical visits and check-ups. There exists a strong association between family stress and preventable health problems as well as between the provision of primary clinical care and preventable health problems.

4. Early Intervention with Children with Disabilities. While not all disabilities are preventable, early and comprehensive supports to children with disabilities and their families both can enhance child development and impact later social costs. In fact, for these reasons federal and state policies have moved toward earlier and more comprehensive supports to serving infants and toddlers with disabilities.

In 1986, the federal government enacted P.L. 99-457, Part H of the Individuals with Disabilities Education Act (IDEA) to encourage states to provide early identification and treatment of disabilities through extension of the purview of IDEA to infants, toddlers, and their families. One of the findings cited by the legislation for this Act was that "there is an urgent and substantial need to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities." In the re-authorization of the Maternal and Child Health Care Block Grant three years later, Congress also declared such family-centered care for infants and toddlers as a cornerstone of its Children with Special Health Care Needs. Both of these pieces of federal legislation were based upon research showing that early diagnosis and treatment of disabling conditions not only improves the ability of children to develop but also is highly cost-effective, because it reduces the need for subsequent, more costly services.[20]

Monitoring Children's Health: Key Indicators (American Public Health Association: Washington, D.C.: 1989).

[20] For a brief description of this legislative history and its implications, see: Bergman, Allan, "States Set Stage for Federal Legislation," Family Support Bulletin (United Cerebral

In educational costs alone, developmental support to children with disabilities starting at birth and extending through age 18 has been estimated to cost $ 37,272, but delaying any educational supports until school age results in 50 % greater costs in special educational services, of $ 53,350.[21] A meta-analysis of a wide range of research studies of early intervention programs concluded that the impacts of such programs are immediate and long-lasting, including improvements in IQ and motor and language skills and in academic achievement, with more intense programs associated with greater gains and efficacy.[22]

5. *Summary*. While substantially less research has been conducted to specifically correlate nurturing in the early years with specific later social, health, and educational outcomes, existing research and the general consensus among child developmentalists posit strong associations between such nurturing and child growth and development, the provision of primary and preventive medical care, and later social costs. These are provided in Table Two.

Clearly, many of these costs are preventable, either through reducing the risk factors themselves, or through supporting families with those risk factors so they can receive the support they need to nurture their children. Finally, while not all families at risk or in stress are identifiable, a large number are. There is the opportunity for near universal contact at the birth of a child (if outreach efforts cannot reach them prenatally), and many already are in an existing public system, although they may be receiving no developmental services.[23]

Palsy Association: Winter 1992-3), p. 2-3.

[21] Graland, C. et. al. (eds.) Early Intervention for Children with Special Needs and Their Families: Findings and Recommendations, Wester Series Paper No. II. Seattle, WA: The University of Washington, 1981 (ERIC Document Reproduction Series No. ED207 278).

[22] Castro, G. and Mastropieri, M.A., "The Efficacy of Early Intervention Programs: A Meta-Analysis," Exceptional Children (Vol. 52: No.5: February, 1986).

[23] For instance, 15,772 children in Iowa under the age of 3, or 13.8 % of all children, currently reside in ADC households. More than three-quarters of all single parents with children under the age of six, 19,475 families, are on ADC. Even if not on ADC, they may be receiving medical services under Medicaid, under provisions covering pregnant women and infants up to 185 % of the poverty level. Therefore, a large proportion of families with very young children who are in poverty and acting as single

TABLE TWO:

INSUFFICIENT NURTURING IN THE EARLY YEARS AND SOCIAL DEVELOPMENT

Insufficient nurturing in the early years, as reflected in abuse and neglect and out-of-home care and also as reflected in lack of primary and preventive health care services or lack of developmental supports to "high opportunity" families, are associated with:

- *untreated health conditions, including failure to fully immunize infants and toddlers, resulting in medical costs to care for chronic and severe health conditions,*
- *emergency room costs,*
- *special education expenditures,*
- *school dropout costs,*
- *neurological disorders and their attendant costs,*
- *child abuse and neglect treatments,*
- *foster placement as a result of this abuse and neglect,*
- *juvenile delinquency, and its attendant costs,*
- *welfare dependency, and attendant costs,*
- *homelessness, and attendant costs, and*
- *mental illness and attendance costs,*
- *criminal behavior, and costs of incarceration as well as costs associated with crime.*

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parents already are involved with a state system. Others may be involved through special education screenings for infants and toddlers or in any number of emerging family support and resource programs.

Clearly, some of the current societal expenditures on remediation, maintenance, and public protection have their basis in failures to adequately nurture children in their first years of life.

C. School Unreadiness and Subsequent Social Costs.

As will be discussed more fully in Chapter Three, the first of the National Educational Goals is that: "all children start school ready to learn." The prominence of this Goal to educational reform on both national and state agendas reflects the recognition that school readiness is key to school success. Teachers of first and second grade often remark that they can identify, at this early age, children who are not going to succeed educationally and will become future drop-outs from school, and often from society. Despite resources provided through federal programs such as Chapter I, the Compensatory Education Act, and through a variety of state efforts, once students experience difficulty in school, it is difficult and expensive to design curricula and practice pedagogy that will be effective in helping them catch up. Much of a child's educational success is based upon motivation, and children who start school behind other children are likely to be discouraged, frustrated, and more likely to tune out.[24]

Some of the factors needed to assure school readiness have been discussed in the previous sections on birth outcomes and nurturing support, which are included as sub-components of the First Educational Goal (see the beginning of Chapter Three for full text of the Goal). An additional important component of school readiness is the provision of high quality, early childhood education programs for pre-schoolers, particularly three- and four-year olds in low-income families. Further, substantial empirical literature is available to connect the impact of providing high quality, early childhood programs for poor children with subsequent child outcomes and goals, which is discussed below.

High Quality Early Childhood Programs for Poor Children. Parents can and should be the primary providers of such developmental and educational support. Nonetheless, the dramatic increase over the last decade in the number of families with pre-school children where all parents are in the work force means that the majority of three- and four-year olds spend a significant part of their waking hours outside their homes. Moreover, a significant number of families, without outside help,

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[24] For this reason, many educators believe retaining children in grade in the early years, whatever their achievement level, is damaging to their long-term educational success.

themselves are not equipped to provide as much developmental support as their children need to begin school ready to learn. The result is that the children of disadvantaged parents begin school life already behind their more advantaged peers.[25]

A large number of studies have demonstrated that providing poor parents with high quality, early childhood programs for their three- and four-year olds can produce dramatic improvements in school readiness and subsequent school performance and social adjustment. A synthesis of the research on quality preschool programs suggests that their impact "stretches from early childhood into the adult years" and that the weight of the evidence is that poor children attending good early childhood development programs are better prepared for school, achieve greater success in school, and enter adulthood more prepared to be contributing members to society.[26] Educationally, these gains have been demonstrated regarding increased intellectual ability (IQ) at school entry, reduced subsequent special education placements, reduced grade retentions, and increased high school completion rates. Socially, these gains have been documented in terms of reduced detentions and arrests for juvenile acts, reduced teenage pregnancies, reduced use of public welfare, and increased employment as adults.

In developing estimates of the cost-effectiveness of high quality early childhood development programs, the High/Scope Educational Research Foundation examined the impact through age 19 of the poor children served by the Perry Pre-School Project in Ypsilanti, Michigan.[27] They found the children served in their

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[25] Berlin and Sum, op.cit., p. 36. These authors contend that "[s]ince schooling is cumulative, children who begin behind stay behind, so that the best predictor of where a child will be in second grade is where he or she is in the first grade, and so on. From the outset, disadvantaged children are limited by language and problem-solving skills they learn from their poorly educated parents. ... [P]arents with limited vocabularies are unlikely to promote extensive vocabulary development in their children."

[26] Weikart, David. Quality Preschool Programs: A Long-Term Social Investment (Occasional Paper 5: Ford Foundation Project on Social Welfare and the American Future: New York, NY: 1989), p. 4.

[27] It is important to stress that the Perry Project was a very comprehensive program which included a strong parental involvement components involving regular home visiting and support to parents, as well as the child's pre-school. The Pre-School programmatic elements are described more fully in the next

Pre-School program were 37 percent more likely to complete high school (67 % vs. 49 % for the "control" group of children with the same backgrounds but not served by the pre-school), 26 percent less likely to require special education services (37 % compared to 50 %), 39 percent less likely to experience juvenile delinquency arrests (31 % compared to 51 %), 45 percent less likely to become teen mothers (64 births per 100 girls compared with 117 births per 100 girls), 66 percent more likely to be employed or in post-secondary school (88 % compared to 53 %), and 44 percent less likely to be on welfare (18 % compared with 32 %). By quantifying the impact in social costs -- on special education services, juvenile delinquency, public welfare, and earnings potential -- they calculated that by the time those children reached age 19, there had been a $ 4 gain to society for every $ 1 expended upon quality early childhood education services.[28] A very recent follow-up study tracking those children as young adults to age twenty-seven has gains continuing to accumulate, with 29 % of the pre-school group earning over $ 2000 a month (as contrasted with only 7 % of the control group); 36 % being homeowners (compared with 13 %); and only 7 % having five or more arrests (compared with 35 %). Taking these into consideration, the Project now estimates a return on investment of $ 7.16 for every dollar invested[29] and have led the Committee for Economic Development, among other business and education groups, to conclude that, for disadvantaged children, "we cannot afford not to invest in pre-school education."[30]

While these findings represent strong justification for greater commitment to quality pre-school programs, and form the core rationale for the federal expansion of Head Start, they also suggest that quality pre-school programs represent only part of the solution to achieving school readiness. Even with the Perry

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part of the framework paper, and themselves are consistent with the findings regarding effective prenatal care services and services to improve the nurturing of infants and toddlers.

[28] Berrueta-Clement, John, Lawrence Schweinhart, W. Steven Barnett, Ann Epstein, and David Weikart. Changed Lives: The Effects of the Perry Preschool Program on Youths Through Age 19. (Monographs of the High/Scope Educational Research Foundation: 1984).

[29] Schweinhart, Lawrence and David Weikart, " Changed Lives, Significant Benefits," High/Scope Resource: A Magazine for Education (Summer, 1993).

[30] Committee for Economic Development. Investing in Our Children (New York: Committee for Economic Development Research and policy Committee: 1985).

Pre-School program, the low-income children participating in the program experienced significantly higher rates of school dropout, juvenile delinquency, adolescent parenting, and welfare dependency than children from middle-income families, with major societal costs. Research indicates that providing high quality early childhood services to poor three- and four-year olds reduces, perhaps by as much as half, the risks those children face of failing to develop fully. It does not eliminate these risks, however. Importantly, these gains also are found to be most pronounced in programs that also include an active parent involvement component.

Summary. As with the provision of services and supports to families prenatally up to age three, high quality early childhood development services for pre-schoolers (three- and four- year olds) have demonstrated their impact across education, health, social, and economic dimensions. These are shown in Table Three.

TABLE THREE:

PRE-SCHOOL DEVELOPMENTAL SUPPORTS AND SUBSEQUENT SOCIAL NEEDS

The absence of pre-school developmental support for low-income three and four year-olds has shown to result in later needs for other forms of support, in particular, for:

- *special education expenditures,*
- *grade retention and its attendant costs,*
- *juvenile delinquency and its attendant costs,*
- *school dropout, lack of employability, and costs in lost economic activity,*
- *lack of post-secondary education, and costs in lost economic activity,*
- *adolescent parenting and welfare dependency, and their attendant costs, and*
- *adult criminal behavior, and its attendant costs.*

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Providing high quality early childhood services can prevent many of these costs and produce a much more productive work force. Research has demonstrated that substantial risks exist, particularly for poor children, for failing to receive strong developmental and educational supports during the pre-school years, and also that high quality programs can provide those supports for many children. For that reason, pre-school programs are generally considered one of the most effective prevention strategies available to states and communities in improving educational performance. At the same time, however, it must be recognized that the research clearly indicates that providing such services can reduce society's needs for spending on compensatory and remediation services, but not eliminate them.

III. Iowa's Current Expenditures on Children and Families

The preceding section described the connection between preventable poor outcomes in the early years of life and subsequent social costs. This section reviews current (1992) public expenditures in Iowa both on prevention efforts generally (applying to all age groups) and on remediation, maintenance, and public protection expenditures that are at least in some part the result of preventable poor outcomes in the early years.

As is true in other states, most of the state and local expenditures from Iowa tax dollars represent investments in society's future -- in primary, secondary, and higher education; in infrastructure such as roads, bridges, and public water systems; and in agricultural and economic development. A significant portion goes to regulatory and administrative services needed to assure compliance with society values and norms, including environmental, occupational health and safety, and business regulation. Still others go for general social goods such as police and fire protection and public lands and recreation.

At the same time, however, when expenditures directly upon services to children and families are reviewed, a substantial portion go for compensatory, remediation, and rehabilitation services; for maintenance payments to mitigate the effects of poverty or lack of economic self-sufficiency; and to placement of persons outside their families and communities for their own or society's protection.

Many of these expenditures are a consequence of poor outcomes for children in the very early years of life and therefore themselves are at least partially preventable.

Table Four presents an overview of public expenditures in Iowa (state expenditures and selected relevant federal and county expenditures) on children and families. Further, it breaks these

expenditures roughly into the following categories: (1) prevention and early intervention services, (2) core educational services (K-12), (3) maintenance and basic needs programs, (4) compensatory, remediation, and rehabilitation programs, and (5) social control and public protection services.

While all these expenditures are needed to address the needs of children and families at different points in their lives, the first two categories clearly represent investments in success. The latter three categories all serve conditions that, at least in part, might not have existed if earlier investments in success had been made.

TABLE FOUR

PUBLIC EXPENDITURES IN IOWA ON CHILDREN AND FAMILIES (1992-3)

Type of Service	State Expend.	Total Expend.
Prevention/Early Intervention	$ 20.6 M	$ 63.3 M
Core Educational Services (K-12)	$ 1,071.9 M	$ 1,980.3 M
Maintenance and Basic Needs Programs	$ 309.3 M	$ 1,014.7 M
Compensatory, Remediation, Rehabilitation Programs	$ 459.2 M	$ 989.1 M
Social Control and Public Protection	$ 130.7 M	$ 168.0 M
TOTAL	$ 1,991.6 M	$ 4,215.4 M

Total Expenditures include state, county, school district, and federal expenditures. Detail on the derivation of these figures is provided in Appendix I.

Table Four clearly shows that, apart from public education, the preponderance of state spending on children and families does not deal with prevention and early intervention but rather with

remediation, crisis-intervention, income maintenance, an public protection. The priorities afforded in public funding of services to children and families is not on the prevention and early intervention side, despite the impact prevention efforts might have on other social expenditures.

Clearly, Table Four shows that for every dollar spent at the state, county, or federal level on prevention and early intervention, over thirty-four dollars are being expended for services that, at least in part, might not have been necessary were greater investments in prevention made.

Finally, since such prevention efforts not only reduce the need for social expenditures but also increase the productive capacity of those who more fully develop their potential, there also would be increased state and federal tax revenue that would occur through this increased economic activity.[31]

As the previous section showed, for each of the services listed under the last three categories, strong associations have been established between preventable outcomes during the early years (pre-natal to school age) and these later expenditures. While exact relationships cannot be drawn between expenditures on prevention in the early years and resulting reductions in society's responsibility to provide remediation, maintenance, and public protection services, Table Four clearly shows that the potential impact is substantial.

IV. The Iowa Context -- Potential for Improvement

Clearly, not all poor outcomes in the early years are preventable. First, some outcomes simply are the result of

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[31] The following is an illustration of the potential gains to society in tax revenue alone, if a modest improvement both in post-secondary education completion participation and completion rates as a result of improved child outcomes in the early years is achieved. Based upon fiscal modelling and forecasting conducted by IBM for the state of Colorado, if improvements in outcomes in the early years produced an increase in the number of Iowa high school graduates who participate in post-secondary education (from 35 % to 45 %), with one-third of those attaining college degrees, the increase in tax revenues to the state would be $ 110 million by the year 2010. This estimate is adapted from the materials developed by: Primozic, Ed, et. al. Integrating Data for Decision-Making (IBM Customer Business Development: Boudler, Colorado: 1991). Tables developed were used by the National Governors' Association for a recent publication. See: McCart, Linda. Every Child Ready for School (National Governors' Association: 1993).

nature. Second, even the best prevention-oriented efforts will not be able to reach everyone who might benefit from them nor always be successful with those they do reach. Third, society currently is invested in prevention activities and there is a finite amount of prevention activity that can occur.

Still, there is ample evidence that -- with respect to improving birth outcomes, early nurturing, and pre-school development -- Iowa has room for substantial gains. The following provides data indicating the room for improvement that exists in Iowa for improving outcomes in the early years.

A. Iowa Potentials for Improving Birth Outcomes. Some poor health outcomes for infants, such as fetal alcohol syndrome, are completely preventable, although it may be difficult in practice to develop effective services to eliminate them. Others may never be preventable. In general, however, since there is a strong association between low (and very low) birthweight and a variety of poor outcomes, one way to gauge the potential of prevention is to examine the degree to which low birthweight might be further reduced.

Iowa's low birthweight rate, of 5.7 % of all live births in 1991, is well below the national average of 7.0 %, but still above the National Health Goals for the year 2000 of 5 %. Meeting the National Health Goals for the year 2000 would constitute a 14 % reduction in the incidence of low birthweight, a substantial improvement over current rates. Moreover, trends over the last several years in Iowa show an increase in the number of low birthweight babies, rather than a reduction (from 1982 to 1991, the incidence of low birthweight in Iowa rose from 4.8 % to 5.7 %)[32]. Clearly, there is a potential for substantially improving birth in Iowa.

B. Iowa Potentials for Improving Early Nurturing. A large proportion of social expenditures that society makes as the result of inadequate nurturing, developmental support, and protection of children as infants and toddlers is preventable if those infants and toddlers can be identified and attention given to their needs. Currently, many come to the attention of society only after significant damage already has occurred -- through criminal or child abuse investigations or through acute medical (rather than primary or preventive) services. Sometimes, even if the damage could not have been prevented entirely, such as instances of extreme abuse or neglect, it could have been

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[32] Child and Family Policy Center. Challenging Trends: Indicators of Well-Being for Iowa Children (1992). Figures were taken from Vital Statistics records maintained by the Iowa Department of Public Health.

substantially reduced through earlier knowledge and intervention.

In Iowa, the number of reported and confirmed cases of child abuse and neglect has increased significantly. Between 1985 and 1992, the number of founded cases of child abuse in Iowa has risen from 4,797 to 5,462, a 13.9 % percent increase. At the same time, the placement of youth into foster care has increased dramatically. Between 1985 and 1992, the number of children placed into care out-of-home rose from 3,509 to 4,942. All these increases are reflective of preventable poor outcomes for children, many of which begin in the early years.

The consequences of abuse and neglect to state spending are very clear. State expenditures alone for child welfare services increased from $ 34.3 million to $ 97.8 million. These represent state expenditure increases substantially above those for the state budget as a whole. In 1985, such expenditures represented 1.62 % of state spending, but by 1992 they constituted 3.05 % of state spending.[33] Even more dramatic than these expenditures has been the growth in the private psychiatric hospitalizations of young children (ages 6-12) for treatment, with most of these the results of serious emotional problems caused by abuse and neglect during the early years. Between 1985 and 1990, there has been a 178.3 % increase in the number of such hospitalizations, with 718 placements of 6-12 year olds, more than 2/3 of whom financed under Iowa's Medicaid program.[34]

Both the recent trends in abuse and neglect cases and the subsequent placements and costs in Iowa and the overall number of cases suggest that Iowa has substantial opportunities to improve the early nurturing of infants and toddlers and fend off later poor outcomes and social costs.

C. Iowa Potentials for Improving School Readiness.

Iowa consistently ranks high among states on educational measures for its youth -- on high school completion rates, on college entrance test scores, and on adult literacy. At the same time, however, over the last two decades there has been little change in high school completion, with approximately one in ten Iowa youth leaving school before high school graduation. The number of children in special education have increased over this

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[33] Source: Department of Human Services, as adapted for the 1991 Child Welfare Retreat on "Making Reasonable Efforts" by the Child and Family Policy Center.

[34] Source: Iowa Health Data Commission. Special tapes run for the Child and Family Policy Center regarding psychiatric and substance abuse treatment hospitalizations of children.

period, from 56,113 in 1981 to 61,178 in 1992. Clearly, some of the costs of school drop-out in Iowa are preventable, as well as a significant amount of special education expenditures.

Further, fewer than half of eligible Iowa children receive Head Start or other pre-school experiences of high quality, although these children constitute a large portion of the special education population and those at-risk of problems in a variety of areas (grade retention, special education use, school drop-out, welfare dependency, juvenile involvement). As with birth outcomes and early nurturing, Iowa has substantial opportunity to improve developmental support for three- and four-year olds and impact longer-term outcomes for children and society.

V. Conclusion

Based upon current evidence, research, and program evaluation, this chapter has drawn a connection between potentially preventable poor outcomes in the early years and subsequent public expenditures. Clearly, some of the expenditures on compensatory, remediation and rehabilitation services, income maintenance, and public protection would have been unnecessary if effective prevention efforts had existed to avert poor birth outcomes, lack of nurturing and support, and absence of developmental supports.

Next, this chapter has examined public expenditures on children and families in Iowa within this context -- distinguishing between investments in prevention and expenditures in addressing problems and concerns. This examination indicates that current investments in prevention are very small compared with expenditures on remediation and rehabilitation services, income maintenance, and public protection.

Third, this chapter has provided information on the current status of children and families in Iowa to demonstrate that improvements in outcomes in the early years (and their resulting potential for reducing longer-term social costs) are possible.

In short, this chapter has sought to suggest the extent to which today's public budget is a reflection of the failure in previous prior years' budgets to invest in prevention. Examining the budget in this way provides a perspective upon the manner in which investments in prevention might be debated.

If prevention initiatives show the potential for reducing the social costs associated with preventable poor outcomes outlined here by even 5 % (e.g. state expenditures upon compensatory, remediation, and rehabilitation services, on maintenance and basic needs programs, and on social control and public protection), the public expenditures savings to society

would be more than $ 108 million, with the savings in state of Iowa expenditures of $ 45 million. If they could reduce those poor outcomes and their social costs by 15 %, the total public expenditure savings would be over $ 325 million, with Iowa savings of over $ 135 million. These figures are more than five times the amount currently invested in prevention and early intervention services. Moreover, they do not incorporate the potential gains to society in increased tax revenues that would accrue from a more skilled and productive workforce. They should be used to assess the potential returns that further investments in prevention might achieve.

This chapter has not indicated what types of prevention investments are needed within Iowa to improve birth outcomes, early nurturing, and pre-school developmental outcomes and therefore to reduce the need for subsequent social expenditures. The next chapter discusses the specific strategies that show the greatest promise in achieving these ends.

CHAPTER THREE:

INVESTING IN THE EARLY YEARS

By the year 2000, all children will start school ready to learn.

- *All disadvantaged [children and children with disabilities] will have access to high quality and developmentally appropriate preschool programs that help prepare children for school.*
- *Every parent in America will be a child's first teacher and devote time each day to helping his or her preschool child learn; parents will have access to the training and support they need.*
- *Children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low-birthweight babies will be significantly reduced through enhanced prenatal care.*

-- *First National Education Goal and Objectives*

I. Introduction

The first National Education Goal is significant for two reasons.

First, it was developed in bipartisan spirit between the nation's Governors and then-President Bush, with the active involvement of then-Governor and now-President Clinton. It therefore represents a bipartisan commitment from the country's top-level policy makers to a prevention/early investment agenda for very young children and their families.

Second, it speaks broadly to what children require in order to achieve this school readiness that goes well beyond a single intervention -- access to and use of primary and preventive health services starting at pregnancy, parental support and nurturing, and high quality and developmental pre-school

experiences. In short, the First Education Goal speaks to the issues raised in Chapter Two regarding preventable poor outcomes for infants and children.

The First Educational Goal leaves two challenges to states and communities:

- to determine the specific services and supports that can help assure that children start school ready to learn, and
- to determine the resources needed to put these necessary services and supports into place for all children who need them.

The second section of this chapter discusses the types of investments in services and supports that appear most promising in improving outcomes for very young children and achieving the First National Education Goal. The third section of this chapter begins to estimate the size of the investment needed for Iowa to adopt such a strategy, taking into account the many existing resources and services already devoted to this effort. The final section calculates the size of the "investment gap" and suggests its importance as a matter for public policy discussion.

II. Improving School Readiness: Components of Effective Service

Increasingly, policy makers, advocates, and administrators have called for development of more comprehensive, community-based, family-centered, flexible, preventive, and holistic services to children and families. Further, while professional services are needed by some families to address specific concerns, publicly provided services should seek to meet family needs by connecting families with natural networks of support -- with relatives, with friends, and with neighborhood and community.

This philosophy in working with families ultimately is given reality within contacts and relationships among people. As exemplary programs in Iowa and around the country have demonstrated, the first key to the success of public programs in preventing poor outcomes leading to school unreadiness is the manner in which a frontline worker responds to families. It requires a worker who has the time and training to respond flexibly and individually to the needs these families have and therefore helps them nurture and provide for their children. Sometimes referred to as family support or family development work, other times referred to as care coordination or home visiting, and still other times referred to as case management, elements of this practice have emerged in a number of different professional practices and service systems. A cornerstone of

most prevention initiatives is this frontline work with families -- people working to help families.

While many family needs can be addressed within prevention initiatives simply by helping families find solutions to their own needs and connecting families with their own natural networks of supports, frontline workers also encounter instances where professional services are needed. A second key to success is in identifying and helping families obtain specialized, professional services, when these are needed. Through establishing relationships with families, frontline workers frequently are in the best position to know when such services are needed and to help families secure and use those services. Among the most essential professional services that families may need to avoid poor outcomes for their children and assure school readiness are the following:

- o primary and preventive health care,
- o screening, diagnosis, and treatment of special childhood conditions,
- o high quality child care and early childhood education supports, and
- o professional services, such as substance abuse treatment or family counseling, where needed to provide a nurturing home environment.

A third key to the success of such prevention initiatives is reaching families who truly need and want such support. While all families need support in raising their children, most families receive the support they need through natural networks of relatives, friends, and community institutions. Reaching families whose children otherwise would be at high risk of poor outcomes requires appropriate outreach and targeting efforts. In effect, for social investments to pay off, it is necessary to identify and reach such "high opportunity families." The next three subsections discuss these three keys to success.

A. Components of Effective Frontline Practice.

The research on the critical components of this effective "frontline practice" is emerging, based upon many exemplary community and state initiatives. While most of these initiatives started from a particular professional orientation (early childhood education, family support, children's mental health, child abuse prevention, child welfare home-based counseling, public health nursing, disability policy), the workers' response to families in effective programs is remarkably similar.

In fact, there is a generic element to this practice, regardless of whether the worker is a nurse home visitor called upon to help families during pregnancy or immediately following the birth of a child, a family development specialist helping a family on ADC achieve economic self-sufficiency, or an early childhood specialist offering advice to parents on parenting and child development. Each worker must establish a trusting and respectful relationship with a family in order to impart any knowledge, and each must be prepared to address immediate family needs that are outside any one area of professional specialization.

In a national symposium on effective services for young children, expert consensus was reached on the following common attributes of programs that have been successful in serving families with young children. In many respects similar to the attributes of successful businesses spelled out in In Search of Excellence, they are based upon Lisbeth Schorr's path-breaking work, Within Our Reach:

1. Successful programs are comprehensive, flexible, and responsive. They take responsibility for providing easy and coherent access to services that are sufficiently extensive and intensive to meet the major needs of those they work with. They overcome fragmentation through staff versatility and flexibility and by active collaboration across bureaucratic and professional boundaries.

2. Successful programs deal with the child as an individual and as part of a family, and with the family as part of a neighborhood and a community. Most successful programs have deep roots in the community and respond to needs perceived and identified by the community. They tend to work with two, and often, three generations, collaborating with parents and local communities to create programs and institutions that respond to unique needs of different individuals and populations.

3. Staff in successful programs have the time, training, skills, and institutional support necessary to create an accepting environment and to build relationships of trust and respect with children and families. They work in settings that allow them to develop meaningful one-to-one relationships and to provide services respectfully, ungrudgingly, and collaboratively. Moreover, front-line workers in these programs receive the same respect, nurturing, and support by program managers they are expected to extend to those they serve.

4. Programs that are successful with the most disadvantaged populations persevere in their efforts to reach the hardest-

to-reach and tailor their services to respond to the distinctive needs of those at greatest risk. Many of the programs providing health, education, and social services to multiply disadvantaged children and families find it essential to combine these services with the supports traditionally provided for families.

5. Successful programs are well-managed, usually by highly competent, energetic, committed, and responsible individuals with clearly identifiable skills and attitudes. Contrary to the common belief that great charisma is essential for running a successful program, managers of effective programs have identifiable attributes that can be learned and systematically encouraged, such as a willingness to experiment and take risks, tolerate ambiguity, and allow staff to make flexible, individualized decisions.

6. Successful programs have common theoretical foundations that undergird their client-centered and preventive orientation. Staff believe in what they are doing. Effective programs seek to replace the prevailing preoccupation with failure and episodic intervention with an orientation that is long-term, preventive, and empowering.[35]

In a subsequent work outlining the clinical and philosophical underpinnings of effective practice, Jill Kinney combined several different iterations of this list into five critical components:

- an emphasis upon building upon family strengths
- a holistic and comprehensive approach
- decision making partnerships with families
- individually-tailored services
- continuous quality improvement through strengthening worker skills
- active setting, modifying, and monitoring family goals

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[35] Schorr, Lisbeth, Deborah Both, and Carol Copple (eds.) Effective Services for Young Children: Report of a Workshop (National Forum on the Future of Children and Families: National Academy Press: Washington, D.C.; 1991). pp. 5-6.

to achieve long-term results.[36]

One power of these attributes is that, in addition to showing promise in helping even very problematic families and their children, they also make common sense. They represent what all families need. As stated earlier, many families already have such support through their existing networks or family, friends, and neighborhoods and community. Unfortunately, those whose children are most at-risk often do not. Exemplary programs have shown success in reaching these "high opportunity families" and thus improve the outcomes for their young children.

Finally, these attributes have been incorporated into policy recommendations regarding service design made by a number of prominent national organizations. The National Center for Service Integration's principles of systems reform offer eight very similar principles.[37] The Council of Chief State School Officers has published a similar list developed by Martin Gerry, former Assistant Secretary for Planning and Evaluation of the United State Department of Health and Human Services.[38] The National Commission for Children has provided yet another call for this approach.[39]

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[36] Kinney, Jill. Concept Paper: Empowering Human Services Clients, Workers and Supervisors (Behavioral Sciences Institute: February, 1993). Included in the concept paper are references to the extensive clinical literature that supports these five attributes, as well as self-assessment tools for determining whether programs embody those attributes.

[37] National Center for Service Integration. Principles of Systems Reform (August, 1993).

[38] Gerry, Martin. A Joint Enterprise with America's Families to Ensure Student Success (Council of Chief State School Officers: Washington, D.C.: 1993). Specifically, those principles are:

1. A structure of services integration.
2. A joint-enterprise type of collaboration among professionals and with families.
3. A universal (noncategorical) and neighborhood-based approach to service provision.
4. A holistic, family-centered and multigenerational service focus.
5. An enabling, responsive, and outcome-accountable management style.

[39] National Commission on Children. Beyond Rhetoric: A New American Agenda for Children and Families (U.S. Government Printing Office: Washington, D.C.: 1992).

If these are the attributes that workers should embody, their work with families similarly has certain developmental characteristics. These have been described as follows:

- o outreach, engagement and trust-building,
- o assessment, enhancement of motivation, and goal setting,
- o step-taking, problem resolution, and continued progress and goal adaptation, and
- o maintenance of positive changes, connections with community, and program graduation.[40]

Again, this approach is largely based upon common sense, although it requires substantial skill to provide. Further, its emphasis throughout is upon building capacities within families to secure the health, social, and developmental supports their children need through existing networks of support rather than through publicly-provided professional services. At the same time, such frontline work also provides for early identification, referral, and treatment of conditions that require professional intervention.

B. The Availability of Professional Services and Supports.

In addition to this frontline mentoring, families also have need for professional services and supports. Again, many families seek and obtain these services without need for any public system support. Some, however, cannot. In fact, one important role of the frontline worker is to connect families to those services, when they are needed. These services deserve enumeration.

As described in Chapter Two, one of the most significant causes for poor outcomes among children is the failure of children to receive primary and preventive health care, including prenatal health care. The availability and use of preventive services for pregnant women and children is commonly recognized as a key component of achieving school readiness. Other important services include high quality child care and childhood

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[40] These "steps" are adapted from Kinney, ibid., the family development training program materials developed by the National Resource Center for Family-Based Services in Iowa City, and from the experiences of the family development and self-sufficiency demonstration grant program, as described in: Bruner, Charles and Megan Berryhill, Making Welfare Work (Child and Family Policy Center: 1991).

education supports, similar to those described for exemplary pre-school programs such as the Perry Pre-School Project. Still others relate to specialized, professional services, such as substance abuse treatment, family counseling, or mental health treatment, where issues require specialized care.

- o screening, diagnosis, and treatment of special childhood conditions,
- o high quality child care and early childhood education supports, and
- o professional services, such as substance abuse treatment, family counseling or mental health treatment, where needed to provide a nurturing home environment.

In some instances, these services may be available within a community. In others, frontline workers can help existing services be better used by addressing some needs before they require more specialized help. In other instances, there may be needs for additional services. This framework paper has not sought to estimate the extent to which the current services are adequate to meet the needs of "high opportunity families."[41]

C. Identifying and Serving High Opportunity Families.

There is no national data system nor scientific assessment tool that identifies families whose children, absent support, will experience poor outcomes. At the same time, however, there are substantial associations that have been drawn between different "risk factors" and subsequent poor outcomes. Further, many of the programs cited in Chapter Two that have demonstrated effectiveness in averting poor outcomes in the early years and subsequent social costs as well (including perinatal programs such as the Elmira Project, other early nurturing programs, and pre-school programs such as the Perry Pre-School Project) have targeted their services to families with specific characteristics.

From both the experience tracing "risk factors" to

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[41] This paper estimates only the investment costs for developing frontline practice. To make estimates on the additional needs for professional services, if any, is beyond the scope of this paper. As important as the availability of such services is the manner in which they respond to families, however. The attributes of effective practice described for frontline practice with "high opportunity families" also should be reflected within all public service systems.

subsequent child outcomes and from the experience of effective programs serving families with these "risk factors," it is possible to describe those families most likely to benefit from services -- those who represent "high opportunity families" for investment of prevention and school readiness services.

Clear relationships have been established between certain demographic "risk factors" in families with infants and toddlers and subsequent child behavior and performance. The 1993 National Kids Count Data Book identifies the proportion of first births in the United States that occurred in families with at least one "risk" factor -- single parenting, teenage parenting, or parenting from a mother without a high school degree. Overall, 45.1 % of all first births were to families with at least one risk factor, with 24.1 % to families with at least two risk factors and 11.0 % to families with all three risk factors. These factors themselves strongly correlate with poor school performance and with poverty at a later age (7-12).[42]

These risk factors also have been strongly associated with other later outcomes for the child. Single parenting is strongly associated with out-of-home placement of children into foster care through reasons of abuse and neglect, with more than one-half of all out-of-home placements occurring in single-parent families.[43] Living in a mother-only family has been shown to more than double the odds of dropping out of school among whites, and to increase by one-third to one-half the likelihood for African Americans and Hispanics.[44] Teenage parents have been shown to be much more prone to child abuse and neglect than older parents, and more than twice as likely to become dependent upon

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[42] 1993 Kids Count Data Book: State Profiles in Child Well-Being. (Annie E. Casey Foundation and Center for the Study o social Policy: Washington, D.C.: 1993).

[43] Some have estimated that 80 % of children in foster care come from the 20 % of families headed by a single parent. In fact, many states, through aggressive practices, have secured IV-E financing for over 60 % of children in out-of-home care. Since IV-E eligibility is based upon ADC eligibility criteria, over ninety percent of IV-E eligible children are likely to be from single parent families.

[44] Bumpass, Larry and Sara S. McLanahan, "The Effect of Family Structure on School Enrollment: A Comparison of Seven Racial and Ethnic Groups" (Institute for Research on Poverty: Madison, Wisconsin: 1987) and McLanahan, Sara S., "Family Structure and Dependency: Early Transitions to Female Household Hardship" (Institute for Research on Poverty: Madison, Wisconsin: 1986).

public assistance for long periods of time (e.g. more than four years). A child's likelihood of dropping out of school has been shown to be more strongly associated with the mother's educational attainment level than such other "predictors" as parental income, family structure (single or two-parent family), or employment status (working, unemployed, or on public assistance).[45] In fact, these "risk factors" have been the basis for identifying and serving families in the effective programs described in Chapter Two.

On a more clinical level, two initiatives designed to screen families at the birth of a child and then offer support to those with strong risk factors similarly have identified from 25 % to 40 % of families as having significant stress and deserving of prevention-oriented services. Hawaii's Healthy Start program and Rhode Island's Family Outreach Program both use screening tools to identify families at risk, with those tools validated as being good tools to identify families for whom, without additional support, later cases of abuse and neglect are likely to be filed.[46]

Taken together, the identification of "high opportunity families" is possible both through examining general backgrounds of families (poverty, single parenting, adolescent parenting) and looking more specifically at family stress. Identification of specific families preferably can occur through outreach activities during pregnancy, but also can be achieved nearly universally through screening at the time of the birth of a child.

III. Identifying the Level of Need for Prevention Services

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[45] Berlin, Gordon and Andrew Sum. Toward a More Perfect Union: Basic Skills, Poor Families, and Our Economic Future (Occasional Paper 3: Ford Foundation Project on Social Welfare and the American Future: New York, NY: 1988). See pages 35 through 37 for citations on a number of studies which have confirmed this relationship.

[46] For a brief description of both programs, see: Center for Assessment and Policy Development. The Children's Initiative: A Framework for Developing and Effective Service Strategy (January, 1993) p. 108-9. The tool used in the Hawaii program, developed by Henry Kempe, has been validated as being highly effective in identifying families where risk of abuse is likely, absent the provision of prevention services. See: Murphy, Solbritt, Bonnie Orkow, and Ray Nicola, "Prenatal Prediction of Child Abuse and Neglect: A Prospective Study," Child Abuse and Neglect (Vol 9: 1985). Pp. 225-235.

As stated in the previous section, Iowa already has programs and services that provide effective services to "high opportunity families" with very young children. In addition, through federal, state, and county programs, many programs expend a part of their resources working with these families, even if they do not take a comprehensive approach to meeting family needs. At the same time, there are some "high opportunity families" who do not receive any services and supports or receive them only in a fragmented or limited fashion.

If a comprehensive prevention agenda is to be developed, it must seek to identify the extent to which current resources serving families can be redeployed and what, if any, additional resources need to be provided. This requires an estimate of the number of "high opportunity families" that exist within Iowa and the extent of the frontline services and supports these families are likely to require. Then it requires an estimate of the resources currently being expended that, in whole or in part, are meant to address these family needs.

Provided here is an estimate of the following:

A. The number of "high opportunity families" with very young children (prenatal to five) in Iowa who could be identified and enlisted to participate with workers in helping their children to school readiness.

B. The cost of providing prevention-oriented frontline services and supports to these families.

C. The resources currently being expended through state, federal, and county funds that offer frontline services and supports to these families.

A. The Number of "High Opportunity Families" in Iowa.

There are several ways to estimate the number of "high opportunity families" that might be served by a comprehensive prevention initiative.

A first approach to approximating the number of "high opportunity families" who would use such services is to examine programs in the country that screen all families at birth according to their risk. As described earlier, both Hawaii's Healthy Start program and Rhode Island's Family Outreach Program screen all infants at birth and identify 25 % to 40 % of those families as being "high opportunity families." In both instances, over three-quarters so identified can be engaged to actively participate in home visiting programs and services.

This would suggest that somewhere between 18 % and 25 % of all families with very young children would be targets for such services in Iowa.

A second approach is to draw from the literature on "risk factors" that connects certain conditions -- adolescent parenting, single parenting, and parenting with a mother without a high school diploma -- to preventable poor outcomes in the early years. According to the 1993 National Kids Count Data Book, the proportion of all first births in Iowa that fell into at least one of these categories was 37.5 %, with 19 % of first births falling into at least two of those categories of risk.[47] In addition, 16.2 % of all families in Iowa with very young children (0-4) live in poverty, another strong risk factor.[48] These demographic indicators of risk suggest a similar proportion of families with young children in Iowa who represent high opportunity families for a prevention initiative as being approximately one-quarter of all Iowa families.

These approximations are consistent with observations of teachers, social workers, and other professionals that the proportion of "at risk" students constitutes at least one-fifth of age cohorts at the elementary and secondary school levels. Currently, there are approximately 160,000 families in Iowa with children under six. If eighty percent of such families can be enlisted to participate with frontline workers, the number of "high opportunity families" to be provided such frontline worker support for some period of time while their children are young is 32,000 families. If the average time such families would require support would be three years, approximately 16,000 would be receiving such support at any given time.

A third approach is to examine the experiences of one Iowa demonstration program serving a "high opportunity" population. Iowa's family development demonstration grant program has found a similar high rate of acceptance of service. When invited to participate through home visits, over seventy percent of families will join. While the family development demonstration grant program only serves families on ADC designated as being "at high risk of welfare dependency," most ADC families with young children qualify as being at that high risk. In Iowa, there are nearly 20,000 single-parent families with children under six currently receiving ADC. Since there are families with young children who are not on ADC or who are not single-parent families

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[47] Kids Count Data Book,. op. cit., p. 64.

[48] Iowa Kids Count. Challenging Trends: Indicators of Well-Being for Iowa Children (Child and Family Policy Center: Des Moines, IA: 1992). P. 9.

who also constitute high opportunity families, this would suggest that more than 15,000 high opportunity families both could be identified and could be enlisted to participate.

Based upon these different approaches to identifying high opportunity families, and assuming that it will not be possible to target with precision only those high opportunity families but that other families will be served as well, it is estimated here that 18,000 high opportunity families could be served by a comprehensive prevention initiative in Iowa.

B. The Costs of Providing Frontline Services and Supports to These Children and Their Families.

The costs involved in providing frontline services and supports to these children and families are a function of the number of families to be served, the amount of services the families need (as reflected in caseload), and the cost of supporting those frontline workers (as reflected in the salary and support needed for such workers and their supervision and training, their travel, and their office and related expenses). The prior subsection has estimated the number of families that could be identified and served. The cost of serving those families also must be estimated, but again can be based upon the experiences both of other state programs and Iowa's program efforts.

In general, workers both in Hawaii's Healthy Start program and in Iowa's Family Development Demonstration grant program find that the following are needed for effective services and supports to families:

- a sufficiently small number of families working with each frontline worker to assure that relationships can be developed and supported, with "caseloads" of 10-15 preferred but 15-20 acceptable (and with worker caseloads expanding as families achieve more self-sufficiency through this work and require less assistance over time);
- long-term developmental work with families that is likely to spread over several years (ideally prenatally to age three), with diminishing contact over time;
- the ability to respond immediately to families' calls for help, including help on weekends or in evenings and for nontraditional supports;
- a very skilled supervision and support system that offers guidance to workers and also handles some of the more challenging families, with this supervision and

direction handling a team of 3-5 frontline workers;

- staff training and staff development activities that are comprehensive and extensive in building competency in working flexibly with families;
- access to a small pool of "flexible funds" that can address immediate concerns of families or of the family support workers so that issues can be dealt with swiftly; and
- group and center-based activities that help meet the needs of families for social contact and experience, including support groups and classes, with these activities arranged in response to the needs and desires of families and largely staffed by the workers themselves.

These experiences from Hawaii's Healthy Start program, from the Iowa Family Development and Self-Sufficiency programs, and from other community-based efforts in Iowa to provide comprehensive supports to families with young children are consistent with the attributes of effective services described earlier in the works of Schorr and Kinney. The caseload reflects both experience in the field and recommendations set forth by such organizations as the Council for Chief State School Officers.[49]

An estimate of the costs of supporting one frontline worker in this capacity is in the range of $ 45,000 to $ 65,000, assuming that paraprofessionals are employed for much of the frontline work. This builds in supervisory, administrative overhead, travel, and flexible fund support as well as worker staffing costs.

The equation in Table Five provides an estimate of the overall costs of providing this frontline service to Iowa's "high opportunity families" with very young children.

This cost estimate of $ 49,500,000 is a gross figure. It does not take into account any existing services that are being expended on these families now that perform some of the frontline services described above. Many current public and private services and supports, provide frontline support to these families. The next subsection identifies the resources that already are being employed to serve these families.

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[49] Gerry, op. cit. Gerry uses the term "family advocate" to describe this work.

TABLE FIVE

CALCULATING THE COSTS OF COMPREHENSIVE FRONTLINE SERVICE TO IOWA'S HIGH OPPORTUNITY FAMILIES

Number of high opportunity families served-- 18,000 families

/ (divided by)

20 families served per worker (assumes a "mature" system where workers will have a mix of new families and families they have served for a period of time)

X (times)

$ 55,000 (cost of supporting those frontline workers, assuming a midpoint cost in the $ 45,000 to $ 65,000 range)

= (equals)

$ 49,500,000

C. The Resources Currently Expended in Providing Similar Frontline Services and Supports.

This form of frontline practice, its partnering with professional services where needed, and its identification of "high opportunity families" is not new to Iowa. In fact, a number of Iowa initiatives are recognized as being at the forefront nationally in supporting this practice. Iowa's family development demonstration grant program, Iowa's Healthy Families initiatives, Iowa's birth-to-three programs, and Iowa's family preservation and family-centered service programs in child welfare all incorporate these principles into practice and seek to work comprehensively with families. Many other locally-supported efforts exist providing family support and meeting at least a portion of family needs through this approach.

In fact, a wide array of state, federal, and local programs and services exist that seek to assist the "high opportunity families" discussed above. This subsection estimates the public

programs and resources devoted to providing some level of frontline developmental support to these high opportunity families.

It also distinguishes between those programs providing prevention-oriented developmental services and supports to families, from those offering other services to families or communities. Many programs, such as section 8 housing, offer needed housing to families but do not offer developmental services. Others, such as Iowa's family preservation services program, offer developmental services but do so as a therapeutic intervention in response to a crisis rather than as developmental assistance as part of a prevention-oriented approach. Still others, such as many of the adolescent pregnancy prevention or child abuse prevention grantees, provide education and primary prevention services seeking to increase community awareness rather than direct work with individual families.

While all these may constitute important and effective services, none of these is included among the resources currently expended in providing frontline developmental supports to "high opportunity families."

In developing this estimate, programs were examined for the proportion of its program expenditure that was involved in providing such frontline developmental supports to families and the proportion of the families being served with children under the age of three (including serving families during pregnancy).

As one illustration, the family development and self-sufficiency demonstration grant program provides services that reflect the comprehensive frontline developmental services described above. At the same time, while nearly all of the FaDSS families constitute "high opportunity families," only a portion are families with very young children. The estimate for the FaDSS program's resources that should be included among the resources already being brought to bear to provide such services is equal to the proportion of families with very young children being served (approximately 60 % of all ADC families) times the total expenditures (approximately $ 1.0 million) on FaDSS, or $ 600,000.

As another illustration, the WIC program provides WIC coupons for pregnant and nursing mothers and young children and offers nutritional counseling to those families. While the WIC program does not offer comprehensive frontline services, the nutritional counseling and support constitute an aspect of the frontline developmental work envisioned. Nearly all of the families served by WIC constitute "high opportunity families" with very young children under the definition provided here. Therefore, that part of the WIC program providing direct

counseling and support to families represents a resource already committed to helping these families. While overall expenditures for WIC (including administrative costs and the value of the WIC coupons) in Iowa are $ 31,400,000, only a portion of that, $ 6,200,000 involve client services, and only a portion of that (about $ 3,100,000) goes for nutrition education and breast feeding promotion, much of that in classroom instruction. The amount that represents some degree of direct frontline involvement with individual families is perhaps half of this amount, or $ 1,500,000. While this service is only a part of the frontline developmental support families need, a new service strategy should use this service and seek to integrate this work into other family work and involvement rather than expending new program funds to duplicate this effort. This is important for two reasons, with the first being fiscal responsibility. In addition, however, some families who participate in WIC develop significant relationships with WIC workers that can be built upon to provide broader, developmental supports. In fact, some of the greatest successes through WIC (and other initially single-issue focussed programs such as maternal and child health programs or infants and toddlers with disabilities programs) have been when WIC workers have gone "beyond the call of duty" to help families meet needs that go beyond nutrition. These opportunities should be recognized in developing a prevention-strategy.

As a third illustration, Iowa's birth-to-three programs provide parenting education services and supports to new parents and some home visiting. Like WIC nutritional counseling and support, this service is not comprehensive, but it is a resource that should be brought to bear in developing a prevention initiative for families with young children. In the instance of the birth-to-three programs, however, while the families served all have very young children, not all constitute "high opportunity families." As universal programs, some of the birth-to-three programs primarily serve families who do not meet criteria of being "high opportunity families," as described earlier. Only that portion that is devoted to "high opportunity families," estimated as one-half of program expenditures, is included here.

The overall number of programs and financing streams which offer, in whole or in part, such developmental frontline services and supports to "high opportunity families" is very significant and spans a variety of professional and disciplinary backgrounds. This reflects a recognition by all these systems of the need to provide more preventive, comprehensive, family-centered, and developmental supports.

At the same time that the number of such programs and financing streams is large, however, the programs that offer truly comprehensive supports are quite small, representing

demonstration or pilot projects in a few selected sites. Larger, statewide programs and financing streams generally offer only small aspects of this frontline, developmental work and are not comprehensive in focus. Appendix II provides a listing of these programs, with estimates of the resources currently being expended within them that could be incorporated into a broad, statewide agenda to provide comprehensive frontline services to all "high opportunity families." Overall, there are substantial existing resources upon which to draw in building a comprehensive prevention initiative, with over $ 15,700,000 currently provided through state and federal funding sources.

The calculations made to construct Appendix II are admittedly crude and do not take into account services funded at the community level or provided through informal support networks such as neighborhood organizations, civic clubs, and churches. At the same time, however, they also do not address the potential needs for additional professional services that such frontline work might identify, including both the need for hard services such as medical care and housing, the need for therapeutic services such as substance abuse treatment or family counseling, or the need for developmental supports such as vocational training or family literacy.

IV. Conclusion

The estimates provided in Sections 2 and 3, however, do present a first cut at describing the gap in the need for developmental frontline services to "high opportunity families" to improve school readiness and positive outcomes and the resources currently being devoted to them. While a substantial amount of funding exists within the current system to address the estimated demand for such frontline developmental work, it falls $ 33,800,000 million short of what has been estimated could be provided in frontline, developmental support were Iowa to invest in a state-wide, comprehensive prevention agenda for "high opportunity families" in the early years of life.

While this provides a very rough estimate of a service gap, it clearly shows the potential for a prevention agenda. The promise of such a statewide agenda for eliminating the need for even a small portion of current statewide expenditures on services in the economic maintenance of families, in remediating poor outcomes, and in protecting the public would clearly make it cost-effective. When such an investment is contrasted with the current and potential future societal expenditures upon compensatory and remediation services, services to meet the basic needs of families unable to economically support their young children, and services providing public protection, the potential for such an investment in prevention is clear.

CHAPTER FOUR:

INVESTING IN PREVENTION --
ISSUES IN DEVELOPING A BLUEPRINT

The first question to ask when setting the state government's goals is, "What do we want for our children who will be the adults who will make Iowa what it will become?" Let us state clearly what we should expect of a child growing up in Iowa. Let us state very clearly what we believe the state's role is in effecting that outcome. Then let us begin to build a state budget from those premises.

If we had embarked on this course in 1980, we would have had tens of thousands of 1-10 year olds today who ultimately could have helped reduce the cost of health care, welfare, crime and unemployment in the state. By the year 2000, we could have made a dramatic impact on the quality of all of our lives.

Such a budget would improve the long-term quality of life in Iowa, create trust in government, and ultimately address those disturbed by present structure and cost. The quality of our young people in Iowa ultimately will define our quality of life and our cost of government.

Tom Urban, Des Moines Register guest opinion, February 1992

The opportunity, and the challenge, to improving the school readiness of Iowa's children is clear. Even though the "costs of failure" to prevent poor outcomes in the early years can only be suggested, they constitute an unacceptable price to society. As the discussion in Chapter Two of current state, county, school district, and federal expenditures showed, the costs borne by society from preventable poor outcomes are of a magnitude far above the investment necessary to implement a comprehensive prevention initiative.

The estimates provided within this framework paper are just that -- estimates. They cannot be precise without much more detailed, community-by-community assessments. They are, however,

sufficient to demonstrate the general magnitude of the response and the redirection of resources needed from Iowa to fully implement a prevention agenda along the lines of that described in Chapter Three.

The challenges to successful implementation such an agenda are more than financial. They involve redirecting existing funding, developing new service capacities, and involving communities and families in service design and development. They require visioning and planning as well as financing.

Financing a Prevention Initiative. The first question policy makers and administrators are likely to raise is how, in tight fiscal times, such a prevention effort can be financed. This is certainly an important question, but it is not an insurmountable one. The fact is that $ 33.8 million represents less than 1 % of the existing annual state budget, and less than 20 % of normal state revenue growth from year to year. As the quote from Tom Urban indicates, it is a matter of priorities -- whether Iowans believe that such an investment should be of sufficiently high priority that it is funded first. Such a commitment need not require new taxes and, in the long term, may constitute an investment that eliminates new demands for tax-supported services.

It also is possible to secure substantial federal participation in such an expanded prevention effort through sources such as Medicaid, IV-A, and IV-E entitlements; such new programmatic resources as the Family Preservation and Family Support Act; existing programmatic funds scheduled for expansion such as Head Start and Chapter I; and project opportunities such as Empowerment Zones and Enterprise Communities). With federal participation, the overall investment required from the state of Iowa is likely less than the full amount of the prevention investment agenda.

The important point in financing such an initiative is that it not be viewed as a budget "add-on," after all current commitments are made. If Iowans truly believe that investments should be made to improve outcomes for children in the earliest and most formative years, such investments should be treated in the budget on a par with existing allocations of funds.

Planning and Dialogue. If this is to occur, however, it will require substantial public dialogue and involvement in shaping this agenda, both at the state and at the community level. This framework paper provides some of the information needed for Iowans to engage in that dialogue, but many critical issues must be resolved through that dialogue. Even if financing were available for this prevention agenda, successful implementation requires a community investment in its design and

implementation. The following represent critical issues to address in furthering such a prevention agenda.

1. *Commitment to Investment.* Such a prevention agenda requires broad-based support and commitment to be effective. It requires that neighborhoods and communities be given, and take ownership for, school readiness. School boards, human service agencies, and all community institutions must commit together to supporting such an agenda.

2. *Community Planning.* The framework paper has only sketched out the existing resources that can support such a prevention agenda. Designing a strategy at the community level will require that agencies and organizations already involved with families with young children be included in the process, to build upon their capacities and to avoid duplication of service. It will require that, within communities, high opportunity families and the neighborhoods in which they reside be identified and services provided that are accessible, culturally appropriate, and embedded within the network of existing support systems. This can be done only at the community level, through careful planning. The end goal of a "seamless" system of supports for families can be created only through a community-by-community planning process.

3. *Adaptation to Local Needs and Strengths and Cross-Sector Involvement.* There is likely to be diversity in the way these prevention services are configured within different communities and diversity in the agencies and organizations selected as service providers. Communities may design different delivery systems, building upon the strengths of their existing services. In one community, schools may be the locus of this support; in another it may be public healthy nursing; in a third it may be a configuration of early childhood programs. In fact, it has been the experience with Iowa's three- and four-year old pre-school programs that in different communities different entities are in the best position to offer such services. This is, however, a fundamentally new way for the state to support services and will require a more flexible state response in providing guidance and support to a range of different service providers. It also is one that is most likely to incorporate existing nonpublic community support systems.

4. *Flexibility for Resource Redirection.* Many of the existing funding streams that finance local programs are categorical in nature, with regulations that make their use within a broader prevention agenda difficult. Greater levels of flexibility need to exist to incorporate existing services into the broader agenda. In addition to adapting to a diverse array of service providers, the state also must broaden the way existing funds can be used in support of such an initiative.

5. *Training and Capacity-Building.* Ultimately, the success of a prevention agenda will only be as great as the skills of those charged with carrying it out. The frontline work described in Chapter Three requires dedicated and skilled workers, not necessarily professionally credentialed but certainly passing a high competency-based practice standard. Training and capacity-building need to be incorporated into the overall design and implementation of the prevention initiative.

6. *Establishment of Accountability Reflecting the Goals of Improving Child Outcomes.* The goal for such prevention efforts is not simply to expand services and reach more families with very young children. It is, in the broadest sense, to improve child well-being and school readiness. This requires the tracking of children's well-being on a far more systematic and extensive way than exists today. It also requires the development of monitoring and evaluation systems that can assist community programs improve their effectiveness. Finally, it requires the development of both proximate (short-term) indicators of success with long-term expectations for improving outcomes and thereby reducing social costs on remediation, maintenance, and public protection.

Next Steps. Fortunately, at both the state and the community level, Iowans have shown the capacity to respond to new challenges. While this is a challenging agenda, it is not an impossible one. Moreover, many Iowa leaders -- from the service community, from the business community, and from the political community -- believe the time has come for such an agenda. As the Committee for Economic Development's report concluded: "It is not whether we can afford to act; it is whether we can afford not to act."

The key to this action, to moving "beyond rhetoric," is simply to begin a serious public dialogue on the promise for success vs. the likely "costs of failure" if no action is taken.

APPENDIX I

PUBLIC SPENDING PRIORITIES
BASED UPON EXPENDITURE ESTIMATES FOR STATE FISCAL YEAR 1992

ITEM	FEDERAL	STATE	COUNTY	TOTAL
PREVENTION/EARLY INTERVENTION SERVICES				
Health and Nutrition				
Extension Service Family Support Workers	$1,800,000			$1,800,000
WIC Nutritional Counseling	$3,118,832			$3,118,832
Medicaid Enhanced Care Coordination	$4,429,352	$2,380,845		$6,810,197
Medicaid EPSDT	$359,445	$193,207		$552,652
Maternal and Child Health Block Grant	$1,698,479			$1,698,479
Community Health Centers	$1,065,349			$1,065,349
Family Planning Services	$1,771,800	$447,000		$2,218,800
Substance Abuse Prevention	$1,667,655	$1,030,887	$2,073,411	$4,771,953
Healthy Families (1993 Figures)		$335,000		$335,000
Infant Mortality Projects (1993 Figures)		$165,000		$165,000
Education				
Head Start	$16,484,282			$16,484,282
Public Law 99-457 - Part H	$723,000			$723,000
Drug Free Schools/Education	$4,065,615			$4,065,615
Innovative Grants for At-Risk Youths		$10,700,000		$10,700,000
Human Services				
FaDSS	$507,040	$417,960		$925,000
Child Abuse Prevention Grants	$188,000	$550,686		$738,686
Adolescent Pregnancy Prevention Grants		$670,000		$670,000
Family-Centered Services		$3,000,000		$3,000,000
Juvenile Justice and Delinquency Prevention Grants	$419,735			$419,735
Community Services Block Grant	$986,520			$986,520
Family Support Subsidy		$648,877		$648,877
Mental Health Education/Consultation			$1,284,606	$1,284,606
Mental Retardation Diagnosis and Evaluation			$36,297	$36,297
Developmental Disabilities Diagnosis and Evaluation		$52,871	$20,945	$73,816
SUBTOTAL	$39,285,104	$20,592,333	$3,415,259	$63,292,696
CORE EDUCATIONAL SERVICES				
Education				
K-12 Education/Foundation		$980,098,541	$903,230,654	$1,883,329,195
Educational Excellence		$91,179,251		$91,179,251
Private School Textbooks		$575,373		$575,373
Chapter 2	$5,232,596			$5,232,596
SUBTOTAL	$5,232,596	$1,071,853,165	$903,230,654	$1,980,316,415

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MAINTENANCE AND BASIC NEEDS PROGRAMS

Health and Nutrition				
Medicaid – Under 65	$399,868,023	$215,090,499		$614,958,522
Indigent Care		$27,173,929		$27,173,929
Food Stamps	$143,337,591			$143,337,591
WIC Program	$27,283,807			$27,283,807
Maternal and Child Health Block Grant	$5,095,438			$5,095,438
Community Health Centers	$3,196,047			$3,196,047
Human Services				
AFDC Payments	$87,633,805	$44,577,574		$132,211,379
Emergency Assistance	$849,226	$853,325		$1,702,551
County Relief			$11,160,281	$11,160,281
Day Care Block Grant	$7,754,522			$7,754,522
Transitional Child Care		$314,125		$314,125
General Administration and Field Operations	$19,200,710	$21,290,223		$40,490,933
SUBTOTAL	$694,219,169	$309,299,675	$11,160,281	$1,014,679,125

COMPENSATORY, REMEDIATION AND REHABILITATION PROGRAMS

Education				
Chapter 1	$44,738,270			$44,738,270
Public Law 99-457 – Section 619	$3,800,000			$3,800,000
Vocational Rehabilitation	$15,736,549	$3,361,735		$19,098,284
Special Education	$24,000,000	$167,200,000	$44,500,000	$235,700,000
Area Education Agencies		$113,737,902		$113,737,902
Human Services				
Child Protection/System Improvements		$1,074,953		$1,074,953
State Supplemental Assistance	$21,792,817	$18,522,933		$40,315,750
State Assistance to Counties for MH/MR/DD		$11,810,333		$11,810,333
State Cases/Local Purchase		$4,451,978		$4,451,978
Mental Health Institutes	$2,188,607	$16,942,045	$17,274,635	$36,405,287
Mental Health Services			$50,031,636	$50,031,636
State Hospital Schools	$48,550,629	$900,071	$21,469,170	$70,919,870
ICF/MRs	$33,139,368		$26,604,004	$59,743,372
Mental Retardation Services			$69,493,916	$69,493,916
CSAP Treatment Funds	$7,387,452	$7,886,826	$2,659,571	$17,933,849
Promise Jobs	$6,113,195	$4,068,808		$10,182,003
Developmental Disabilities Services			$6,537,159	$6,537,159
Services for Handicapped Children			$121,915	$121,915
Social Services Block Grant	$31,900,000			$31,900,000
Community Services Block Grant	$2,959,558			$2,959,558
General Administration and Field Operations	$19,200,710	$21,290,223		$40,490,933
Foster Care (IV-E)	$11,100,000	$59,890,069		$70,990,069
Home-Based Services (IV-B)	$3,364,000	$15,938,838		$19,302,838
Adoption Services	$2,704,000			$2,704,000
PMICs	$7,606,488	$4,162,796		$11,769,284
Toledo Juvenile Home		$4,381,976		$4,381,976
Court-Ordered Services		$3,599,687		$3,599,687
Juvenile Court Referee			$661,176	$661,176
Juvenile Court Appointed Attorney			$4,259,012	$4,259,012
SUBTOTAL	$286,281,643	$459,221,173	$243,612,194	$989,115,010

SOCIAL CONTROL AND PUBLIC PROTECTION PROGRAMS

Juvenile Justice				
Eldora Training School		$7,507,768		$7,507,768
Juvenile Probation			$940,150	$940,150
Corrections Education		$2,032,985		$2,032,985
Indigent Defense of Juveniles		$3,626,887		$3,626,887
Youth Guidance		$1,909,500	$6,643,711	$8,553,211
Adult Corrections				
Adult Correctional Institutions		$77,090,926	$28,341,865	$105,432,791
Adult Detention Services			$1,441,938	$1,441,938
Public Defender Services		$6,500,000		$6,500,000
Community Corrections		$31,993,636		$31,993,636
SUBTOTAL	$0	$130,661,702	$37,367,664	$168,029,366
TOTAL	$1,025,018,512	$1,991,628,048	$1,198,786,052	$4,215,432,612

Note: SCHOOL FOUNDATION AID: The $903,230,654 is the TOTAL statewide school levy minus the $44,500,000 DOE identified as being used for additional services for children with disabilities. The total statewide school levy is $947,730,654 before the application of any property tax credits, according to DOM.

Note: SPECIAL EDUCATION LOCAL COST: This is the "Excess funding for intructional purposes for children with disabilities" according to DOE's special education consultant.

Note: MATERNAL AND CHILD HEALTH CARE BLOCK GRANT AND COMMUNITY HEALTH CENTERS (25% Prevention, and 75% Basic Needs Programs). Most services are for basic medical coverage rather than for developmental support. Most participants seek such medical care because they do not have the resources to purchase health services.

Note: COMMUNITY SERVICES BLOCK GRANT (25% Prevention, and 75% Remediation). Most funding under this block grant supports organizations which offer income support or other services for low income families, but community action agencies increasingly are doing more preventive developmental work.

Note: WOMEN, INFANTS AND CHILDREN PROGRAM (50% Prevention, and 50% Basic Needs Programs). For explanation, see discussion in Chapter 4.

Note: FAMILY-CENTERED PROGRAM (15% Prevention, and 85% Remediation) Primanly used for families already experiencing serious child abuse and neglect concerns but sometimes used to intervene earlier For this reason, a proportion is put into prevention

Note: YOUTH GUIDANCE The state's $19,905 is the state share of costs for juvenile detention The county's $6,643,711 includes county costs at Toledo, county juvenile detention, and county shelter care costs

Note: STATE SUPPLEMENTAL ASSISTANCE State and Federal expenditures are based upon the following calculations with information provided by DHS Total number of SSA bed days for FY 1992 is 1,680,248 The state cost per bed day is $6 61 The client cost per bed day is $12 97 (This is primarily the client's social security and SSI minus the personal needs allowance There is an insiginificant part of this cost that comes from individual client trust funds) The state and federal costs on the table result from multiplying the cost per bed day by the number of bed days for FY 1992

Note: STATE CASES/LOCAL PURCHASE. This can be considered as the state's supplementation of the Social Services Block Grant

Note: MHI COUNTY COSTS. This number comes from the counties' report to DHS on MH/MR/DD expenditures. This has historically been considered the most accurate accounting of county expenditures for these services. An LFB report for the MH/MR/DD/BI Task Force shows an FY 1992 county expenditure of $24,458,012. The LFB data comes from the audited reports of the MHI's and among other items includes county payments for substance abuse at the MHI's.

Note: GENERAL ADMINISTRATION AND FIELD OPERATIONS (50% Basic Needs Programs,and 50% Remediation). State administration of programs involves a variety of activities, half involve support programs and half involve remediation.

Note: OTHER COMMUNITY BASED SERVICES. This is based upon the following calculations Total Community Based Services Expenditure for FY 1992 was $3,822,587 according to LFB The appropriations bill HF 479 earmarked $670,000 for Adolescent Pregnancy Prevention Grants, and $550,686 for Child Abuse Prevention Grants The $2,601,901 is what remains after these earmarked funds are subtracted.

APPENDIX II

CURRENT INVESTMENTS IN PREVENTION IN THE EARLY YEARS (PRE-NATAL TO FIVE) TO "HIGH OPPORTUNITY FAMILIES"

Investments in Workers Providing Mentoring and Guiding Support to Families

Child Development Coordinating Council Birth-to-Three Programs	$ 250,000[1]
Child Development Coordinating Council Pre-School and Transition Programs	$ 600,000[2]
Chapter One early childhood programs	$ 120,000[3]
Head Start parent advocates	$ 1,600,000[4]
Child Abuse Prevention and Healthy Families	$ 710,000[5]
Family Development and Self-Sufficiency Grants	$ 600,000[6]
Extension Service Food and Nutrition and Family Support Education services	$ 750,000[7]
WIC Nutritional Counseling and Breast-feeding Education Services	$ 1,500,000[8]
Adolescent Pregnancy Prevention Grants	$ 500,000[9]
Family-Centered Services	$ 1,500,000[10]
Medicaid enhanced care coordination and EPSDT services	$ 3,400,000[11]
Maternal and Child Health Block Grant	$ 700,000[12]
Community Health Centers	$ 200,000[13]
Infant mortality grants	$ 130,000[14]
State Human Investment Council/JOBS Workers	$ 2,400,000[15]
CSAP prevention funds	$ 750,000[16]
TOTAL ESTIMATE	**$15,460,000**

APPENDIX II NOTES

1. Birth-to-three programs serve wide range of families. Here, it is assumed one-half of program funds serve high opportunity families.

2. Iowa's pre-school programs for at-risk youth primarily offer pre-school programs for children, but also assist parents and provide some support. As with the Head Start program (see below), it is assumed that approximately 10 % of the funding for these programs provides family support to "high opportunity families."

3. Chapter One funds can be used for early childhood programs, but over 95 % of Chapter One funds in Iowa are used for children in school. There were only 24 funded Chapter I early childhood programs in 1992, with only four explicitly providing family support services, such as health care and nutritional counseling and parent involvement and home visiting. Those four programs, which also provided pre-school support, received approximately $ 120,000 in funding.

4. The vast majority of the funding for Head Start goes to the pre-school component, although there is family involvement in both delivering Head Start and through 64 home-based staff in the state offering parent involvement and advocacy supports. The figure here assumes that about 10 % of Head Start funds actually are deployed in providing frontline support to families themselves, as opposed to pre-school programming for their children.

5. The Iowa Chapter of the National Council for the Prevention of Child Abuse helps administer both the child abuse prevention grant funds and the new Healthy Families program, modelled after Hawaii's Healthy Start. The funding they receive for Healthy Families ($ 335,000) goes entirely toward supporting "high opportunity families" with very young children. The funding they receive for prevention activities ($ 710,000) goes in part for direct services and in part for primary prevention efforts, with more than half designated here as serving high opportunity families.

6. Approximately $ 1.0 million of the JOBS program monies are spent on the FaDSS programs, which offer comprehensive supports to families at-risk of long-term welfare dependency. Approximately 60 % of these families have very young children, so 60 % of the $ 600,000 is included.

7. Through the cooperative extension service, there are a number of paraprofessionals who provide nutritional counseling and education to "limited resource" (low income) families and the extension service also provides other family support education services. Overall, family field specialist salaries total approximately $ 1.5 million in Iowa, not including FNEP workers. Approximately 1/3 of the total funding pertains to direct work with "high opportunity families."

8. WIC requires nutritional counseling as a condition for receiving coupons, which is primarily conducted through classes, although women also receive breast-feeding instruction and counseling through one-on-one or small groups. Most WIC participants constitute "high opportunity families," although WIC has not been stigmatized and a number of families participate who do not meet that definition. Therefore, of the service dollars within WIC, approximately 1/2 are considered to reflect family support services.

9. Some of the grant funding under the adolescent pregnancy prevention grant programs goes toward primary prevention services, but most provides direct services to pregnant adolescents or to supporting adolescents delay pregnancy. Approximately 80 % of the funds are included as funds directly supporting adolescents.

10. While most families served by the child welfare system are those who require remediation services and whose children already have been neglected or abused, the system does provide some degree of prevention/early intervention services, here placed at approximately 10 % of the services provided.

11. Most services provided under Medicaid are for clinical health services, that meet basic health needs. Iowa does provide for some "case finding" services and "enhanced care coordination" under Medicaid that includes nutritional counseling and psycho-social assessment, and a portion of that funding is included here.

12. The maternal and child health block grant funds services to families that provide primary and preventive health care, but can extend to provide general human support. Some offer home visiting services and outreach services to reach families who otherwise would not obtain primary and preventive care. While the bulk of MCH funds are expended upon health care, a portion (here estimated at 10 %) provides more general family support.

13. Similar to maternal and child health programs, Community and Migrant Health Centers primarily provide clinical care but do offer some family supports. While MCH programs almost exclusively serve pregnant women or families with very young

14. Similar to maternal and child health programs, Community and Migrant Health Centers primarily provide clinical care but do offer some family supports. While MCH programs almost exclusively serve pregnant women or families with very young children, CHCs serve many single adults or families with no young children. Therefore, only 5 % of their funding is attributed to family support activities.

15. Funding during the 1992 session were several demonstration projects to reduce infant mortality in high infant mortality areas through providing more intensive outreach and support services. While some of the $ 165,000 funding has gone for basic medical services, most has gone to family support and outreach activities.

16. The state welfare reform initiative, SHIP, is significantly expanding the work with families in developing self-sufficiency contracts and goal-setting, with approximately $ 8,000,000 in FY 94 for such involvement with families on ADC. This work will not be of the comprehensive nature described in this paper and will involve monitoring and enforcement as well as support. Here, it is estimated that over one-quarter of this work currently fits into the prevention agenda described.

17. A portion of the CSAP prevention funding does involve work with families with young children, although much goes for primary prevention services or for work with persons who are not in families with young children. The figure provided here represents approximately 15 % of the total funding for prevention efforts provided under CSAP, the state, and the counties.

Blueprint Investment Principles

The following principles govern the *Blueprint* investment strategy. They are different from most public program expenditures, but are based upon Iowa programs with records of success:

Community-designed and owned. Communities have broad discretion on the service strategy, building upon community strengths and resources.

Non-bureaucratic. Service strategies are flexible, with individualized responses to families that, to the maximum extent possible, draw upon family, neighborhood, and community supports rather than professional services.

Collaborative. Service strategies build upon and use resources already serving at-risk families.

Voluntary. Services are based upon voluntary participation, although creative and persistent outreach will be employed.

Stressing Family Responsibility. Services emphasize family responsibility and place high expectations upon families, empowering families to develop and holding them accountable for achieving their goals.

Results-oriented. Community initiatives are disciplined and establish clear outcome-expectations for improving the well-being and school readiness of children in their community.

Fiscally-responsible. The state tracks investments and their impacts upon future social needs and costs, to assure the overall initiative achieves results and reduces reliance upon the need for remediation and corrective action service expenditures.

For More Information

Copies of the following materials that describe the *Blueprint*, the condition of children in Iowa, and Iowa opinions toward children and families are available through Iowa Kids Count:

A Blueprint for Iowa's Young. Describes the process by which the *Blueprint* was developed, the principles upon which it is based, and the guidelines under which a state investment should be made.

Reinventing Common Sense. The 1994 Iowa Kids Count Data Book, which outlines the research and fiscal analysis used to establish the $ 33.8 million investment budget, highlights six successful Iowa demonstration programs serving families with young children, and describes decade-long trends in child well-being in Iowa.

Where Iowa's Children Rate. Reports the results of a public opinion poll of five hundred Iowans, showing strong concern for the state of Iowa's children and rating children's issues at the top of the state policy agenda.

Copies of these publications are available through Iowa Kids Count, 100 Court Avenue, Suite 312, Des Moines, IA 50309, (515) 280-9027, for a charge of $ 1.50 per publication, to cover shipping and handling.

A Blueprint for Iowa's Young

A community prevention agenda to help all kids succeed.

PS 02431

The Case for Investment

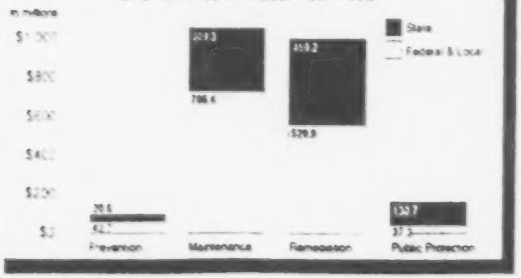
Taxpayers support billions of dollars of public services for Iowa's children and families. Unfortunately, many of these dollars are spent to address problems that are preventable. Prevention services are particularly effective when they start early. Today in Iowa, however, few public programs work with families with very young children (prenatal to five) before problems occur. The state has yet to make a comprehensive, statewide commitment to invest in prevention.

The *Blueprint for Iowa's Young* outlines a comprehensive prevention initiative. It is based upon a careful analysis of current public spending and on effective prevention services. It focuses on families with very young children and provides a rational strategy for Iowa to achieve the First National Education Goal -- that all children start school ready to learn.

The *Blueprint* calls for an initial commitment of $ 33.8 million annually in new state funding. This investment is required if Iowa is to reduce the need for continued public expenditures to address preventable problems. These expenditures -- on remedial services (in health, education, and human services); on adult dependency (in welfare and health care costs); and on public protection (in juvenile and adult corrections) -- have become increasing drains on state and local budgets (see Chart for current public spending).

Chart One

Public Non-education Spending on Children and Families in Fiscal Year 1992



Source: Re-ordering Common Sense: Kids Count Data Book, 1992

In the long-term, the state can save over $ 3 for every $ 1 invested in the Blueprint. It is both a humane and a fiscally responsible approach to Iowa's youngest citizens.

In the long-term, if the need for public expenditures to address preventable problems can be reduced by as little as 5 %, the state will save over $ 3 for every $ 1 invested in the prevention initiative. The $ 33.8 million expenditure is based on careful estimates of the number of families with very young children whose children would benefit from proven prevention efforts.

Blueprint Development: An Iowa Process

The service strategy in the *Blueprint* builds upon Iowa and national programs that have shown success in helping families with young children. These programs share common features that are included in the *Blueprint*. They are designed at the community level, voluntary, comprehensive, and family-focused. They emphasize growth and self-sufficiency and are results-oriented. The *Blueprint* establishes the mechanism for implementing this investment at the community level.

The *Blueprint* was developed as part of the Iowa Kids Count Project. Guided by a 120-member Leadership Collaborative representing community and state leaders from diverse backgrounds, Iowa Kids Count has tracked trends and publicized the worsening plight of Iowa's children. Recognizing that publicizing these trends is not enough, the Leadership Collaborative first developed a vision for Iowa's children and then held town meetings around the state.

The *Blueprint* offers a specific strategy for improving the well-being of Iowa's youngest children.

Communities will develop new approaches to working with families of very young children who are most at risk of not starting school ready to learn. Community-based workers will provide developmental support to fifteen to twenty families, establishing long-term relationships and assisting those families to:

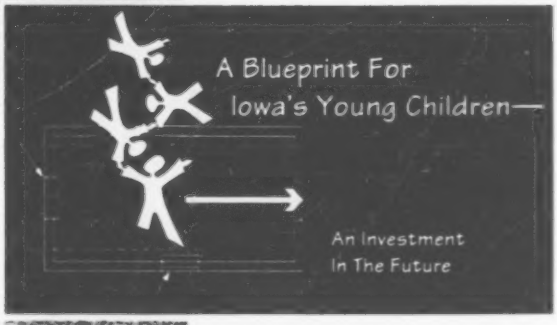
- o secure necessary preventive and primary health care for their children,
- o provide developmental support, and
- o create safe and thriving home environments.

This service strategy is based on a number of small-scale, successful Iowa programs in the areas of child abuse prevention, welfare reform, child development, perinatal health care. It represents a common sense approach that builds capacity rather than fosters dependency upon public programs. It is based upon Iowa values of community and family responsibility.

The *Blueprint* makes both social and economic, sense. It improves the lives of children and families and is fiscally-responsible.

It is not a matter of whether we can afford to invest in our youngest citizens, it is a matter of whether we can afford not to invest.

A New Way Of Doing Business



Iowa's children are in trouble, and Iowa's future depends on our response. We need a new way of doing business. The Blueprint for Iowa's Young Children calls for investing in approaches that lead to the strength and independence of families, so they can prepare their children for school and the future. It suggests an approach based on common sense: working with families with very young children before problems occur.

The Blueprint, an outgrowth of three years of study and examination through the Kids Count project, offers a specific strategy for improving the well-being of Iowa's youngest children. It embodies philosophy, process, and program characteristics that represent a break from traditional approaches that are categorical, inflexible, and burdensome to use.

The Blueprint uses solutions that build on the strengths of communities and families.

The Philosophy

"A New Community Strategy"
The Blueprint investment strategy promotes this philosophy by emphasizing the following principles that :

- build upon community strengths and resources
- use flexible service strategies that draw upon community, family, and neighborhood supports
- build upon and use resources already serving families
- use voluntary participation with extensive outreach
- empower families and enable families to take responsibility
- focus on achieving positive outcomes which document the improved well-being of children
- use strategies that are fiscally responsible

The Process

The Blueprint outlines a process for finding solutions for families that differs from traditional state-planned and administered processes.

Traditional		Blueprint
State Administered	→	Community-Developed
Central Authority/Control	→	Community Capacity Building
Procedure-Based	→	Vision-Based
Discrete Areas of Responsibility	→	Collaborative
Agency-Driven	→	Consumer-Driven
Process-Accountable	→	Results-Accountable
Routine/Low-Risk	→	Innovative/Risk-Taking

To find solutions that work for families, we need to break with traditional agency roles & responsibilities.

The Program

The programs themselves, while they will be developed based on community needs and strengths, resources and styles, will break from traditional ways of providing assistance to families and emphasize the critical role of frontline workers.

Traditional		Blueprint
Individual as Client	→	Family as Client
Families as Recipients	→	Families as Partners
Based on Family Deficits	→	Based on Family Strengths
High Caseloads	→	Low Worker-Family Ratios
Workers Carry Out Routines	→	Workers Problem-Solve with Families
Workers Support Organization	→	Organization Supports Workers
Emphasis on Professional Services	→	Emphasis on Community Supports
Success Measured by Clients Served	→	Success Measured in Success of Families

Iowa needs a new approach.

Things are getting serious in Iowa for families with very young children.
Communities and neighborhoods know their own problems.
Doing business differently through the Blueprint's proposed $33.8 million prevention agenda will enable communities to respond to their problems and enable families to make improvements in their own lives.....

It is not a matter of whether we can afford to invest in our youngest citizens — we can't afford not to.

For more information, contact:
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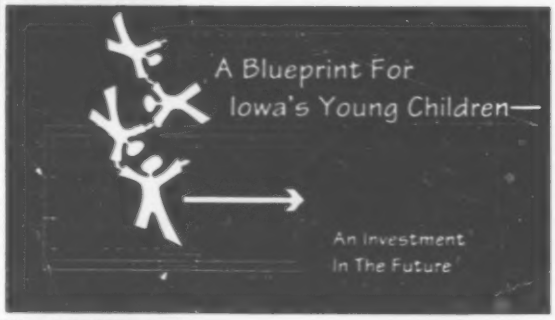
Children in Need — Society at Risk



Children from birth to age five are our most vulnerable citizens. They need a safe, nurturing environment in order to become strong children ready to take advantage of school, and to eventually become productive citizens. When these needs are not met, the documented results are higher rates of school failure, delinquency, unemployment and poverty. Iowans know that many families are having a hard time providing a good environment for their children — some of the signs include:

Poverty: 18% of Iowa children aged birth through age four are living in poverty
Teen Pregnancy: Increased 52% since 1980
Child Abuse: Number and rate of founded cases doubled since 1982
Foster Care: Rate of placement increased by 36% since 1985, costs doubled

The Iowa Kids Count project estimates that there are 18,000 families with children from birth through age five which could benefit from supportive prevention efforts. Without such efforts, the costs to them and to society will continue to grow.

When children suffer, society also pays a price.

Iowa's Current Costs For Preventable Problems

Apart from public education, most public expenditures on children and families — over $2 billion in 1992-1993 — is spent on problems that can be prevented. These expenditures represent an increasing drain on state and local resources. The Blueprint for Iowa's Young Children calls for an initial commitment of $33.8 million annually in new state funding to reduce the need for continued public expenditures to address preventable problems.

If the need for public expenditures on poor outcomes can be reduced by as little as 5%, the state will save over $3 for every $1 invested in the prevention initiative.

EXAMPLES OF PREVENTABLE POOR OUTCOMES

Health:
- Low Birth weight, neonatal intensive care
- Chronic and severe health problems
- Mental health and neurological problems

Education
- Grade retention
- School drop outs

Human service
- Child abuse/neglect
- Foster care
- Juvenile delinquency

Adult dependency
- Welfare dependency
- Criminal behavior/incarceration
- Unemployment and lost economic activity

Preventing Poor Outcomes? . . . Iowa Has Home-Grown Answers

At the age of 17 with three children, stressed by poverty, isolation, and dead ends, Linda could have added her own children to a chain of dependency and failure. Instead, today she is a nurse and a volunteer counselor with other young mothers, and her family is thriving. She didn't make these changes by herself. She became part of a program that provided help with parenting, peer support, a counselor who was her advocate, help with job placement, baby-sitting, and a tutor.

A handful of Iowa programs, like the one that helped Linda, have demonstrated that comprehensive, family-focused prevention is successful in helping families with young children. The essential, common features of these programs form the basis of the Blueprint strategy:

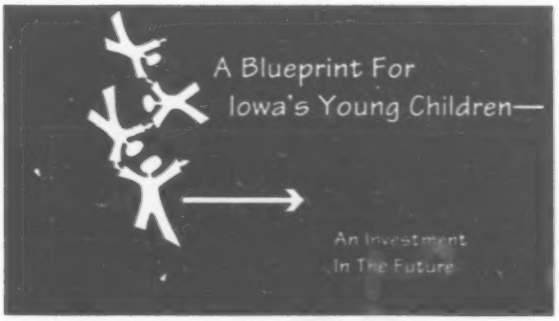
- They are designed at the community level and build upon existing community strengths and resources.
- They are flexible, voluntary, comprehensive, and draw upon family, neighborhood and community supports.
- They emphasize growth and self-sufficiency, and are results-oriented.

Under current funding, these programs and others are reaching only a small portion of families in need.

Return on Investment: It's a Matter of Choice

The service strategy in the Blueprint represents a common sense approach that builds capacity rather than fosters dependency upon public programs. It is based upon Iowa values of community and family responsibility and offers a specific strategy for improving the well-being of Iowa's youngest children.

It is not a matter of whether we can afford to invest in our youngest citizens—we can't afford not to.



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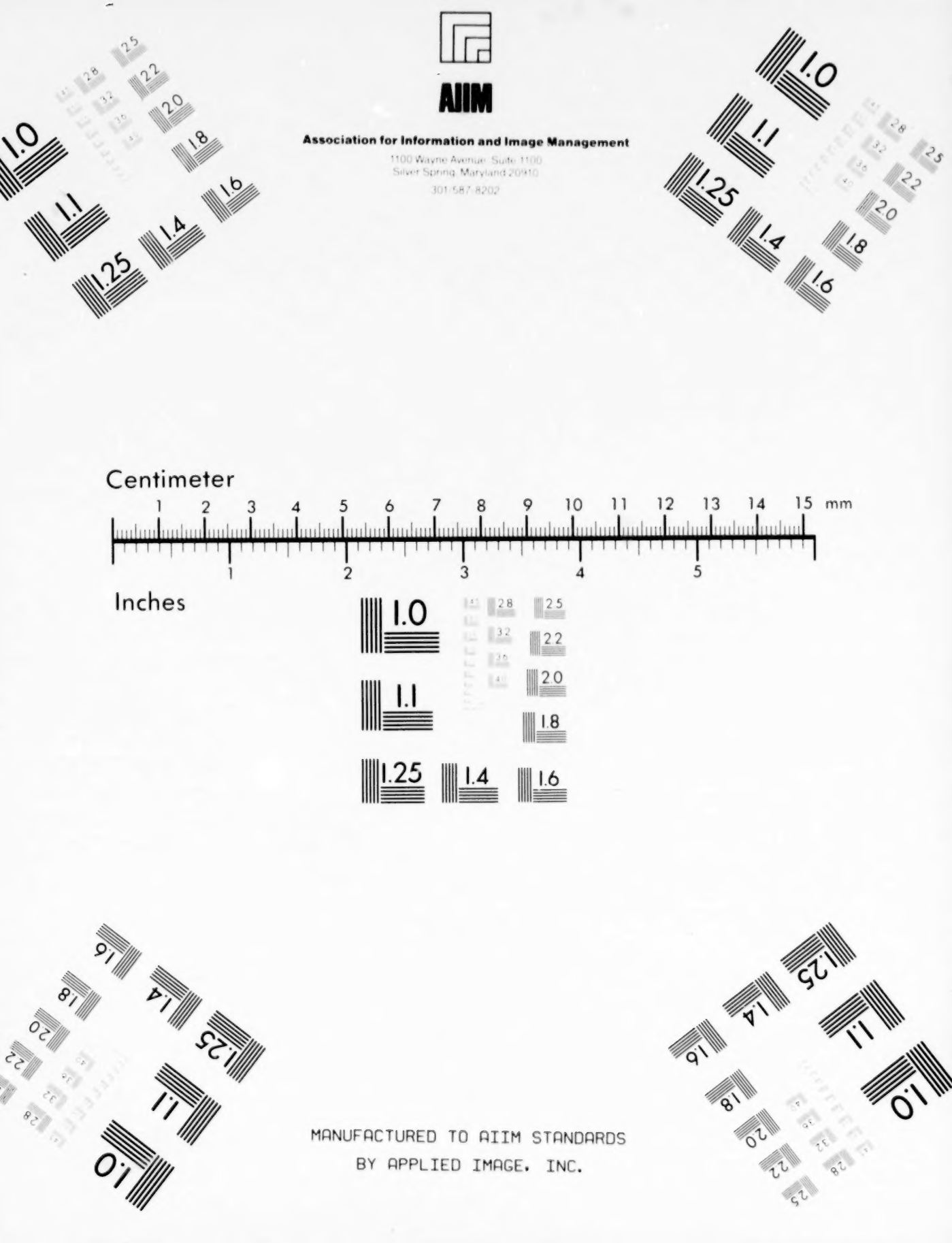
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